

MISSOURI



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Message from the President

Nurse Licensure Compact - A State Nursing License Recognized Nationally and Enforced Locally

Charlotte York, LPN, President

The nurse licensure compact bill was filed this legislative session by Senator Scott Rupp (R-District 2) as Senate Bill 137, Senator Jim Lembke (R-District 1) and Representative Don Well (R-District 147).

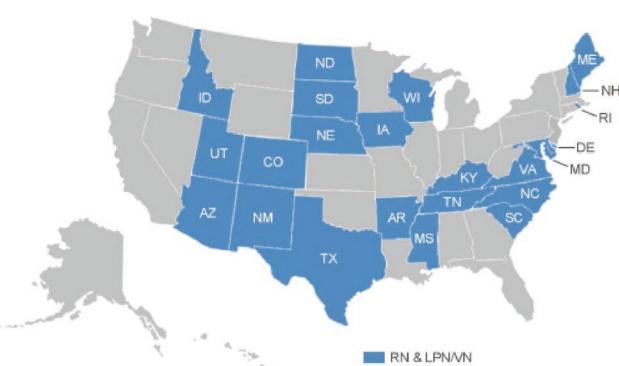
The nurse licensure compact would allow a nurse's license to work like a driver's license. The nurse would be required to hold a license in his/her state of residence. The compact would, therefore, allow mutual recognition of licensure in all states which have legislated the compact. Nurses will be required to declare their primary state of residence. Primary state of residence verification may include driver's license, federal income tax return or voter registration. State of residence was chosen because nurses practice in multiple states but have one primary residence.



York

- Enhanced discipline and information-sharing among participating states.
- This is not a new concept. Thousands of nurses working in the military, in federal facilities and for federal agencies practice on the basis of being licensed in one state and then allowed to practice in any federal setting. This occurs through exemptions defined in each Nursing Practice Act.
- Does not change nurse's due process.
- Does not change the state's authority to regulate nursing.
- Decreases monetary and regulatory burden for nurses.
- We can increase the access to care through the practice of nursing across state lines using telecommunications such as telephones, satellite, and computers to teach, consult, triage, advise or provide direct services. A nurse in Iowa may be on a hotline providing advice to clients in Missouri. Nursing faculty from other states may teach via satellite. Some nurses may practice from offices to patient homes using cameras and computer technologies.

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Key Points to the Nurse Licensure Compact

- Nursing workforce would be more mobile.
- A centralized database provides access for one-source verification of a nurse's qualifications for practice.
- Improved access to licensed nurses during a disaster or other time of great need for qualified nursing services.
- Improved access to nursing care.

current resident or



Authored by Lori Scheidt, Executive Director

Legislative Update

Our newsletter articles are due approximately two months before the newsletter is actually published. By the time, you receive this newsletter the legislative session will have ended. In order to determine if bills actually passed, you can check the final disposition of bills at <http://www.moga.mo.gov/>



Scheidt

Nurse Licensure Compact

The nurse licensure compact was filed as Senate Bills 137 & 237 and House Bill 514. Senator Scott Rupp (R-District 2) filed Senate Bill 137, Senator Jim Lembke (R-District 1) filed Senate Bill 237 and Representative Don Well (R-District 147) filed House Bill 514.

Nursing Student Loan Program

Representative Tom Loehner (Republican-District 112) filed House Bill 247 and Senator Dan Clemens (Republican-District 20) filed Senate Bill 152. Both versions of the bill revises the definition of "eligible student" as it relates to the Nursing Student Loan Program to add individuals seeking a doctoral degree in nursing, nursing

practice, or a student with a master of science in nursing seeking a doctorate in education on a full- or part-time basis to be eligible for the program.

Advanced Practice Registered Nurse Collaborative Practice Agreements

Senator Delbert Scott (Republican-District 28) filed Senate Bill 509 which would clarify the percentage of records the collaborating physician must review.

Advanced Practice Registered Nurse Prescribing Physical Therapy

Representative Rebecca McClanahan (Democrat-District 2) filed House Bill 563 which would allow advanced practice registered nurses, who have a collaborative practice agreement with a physician, to prescribe physical therapy if the delivery of the services is within their scope of practice;

Physician Assistant Controlled Substance Prescribing Authority

David Sater (Republican-District 68) filed House Bill 275 and Senator Delbert Scott (Republican-District 28) filed Senate Bill 405. Both bills would allow a physician assistant to prescribe any controlled substance listed in schedule III, IV, or V of section 195.017, RSMo, when delegated the authority to prescribe controlled substances in a supervision agreement.

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School Nurse Pay

Representative Sue Allen (Republican–District 92) filed House Bill 456 and Senator Tom Dempsey (Republican–District 23) filed Senate Bill 135. It would require school districts to pay registered professional school nurses on the same salary schedule as teachers.

Controlled Substance Schedules

Representative Clint Tracy (Republican–District 158) filed House Bill 615, Representative Jeff Roorda (Democrat–District 102) filed House Bill 623, and Senator Jason Crowell (Republican–District 27) filed Senate Bill 160. These bills would change the scheduling of ephedrine, pseudoephedrine, and phenylpropanolamine to be Schedule III controlled substances.

Prescribing Psychologists

Representative Bob Dixon (Republican–District 140) filed House Bill 536 and Senator Jack Goodman (Republican–District 29) filed Senate Bill 204 which would authorize the licensure of prescribing psychologists.

Pharmacist Law

Senator Bill Stouffer (Republican–District 21) filed Senate Bill 369. Currently a licensed pharmacist may administer influenza vaccines. This bill would add the ability for them to administer pneumonia and shingles vaccines by written physician protocol.

Important Telephone Numbers

Department of Health & Senior Services (nurse aide verifications and general questions)
Missouri State Association for Licensed Practical Nurses (*MoSALPN*)
Missouri Nurses Association (*MONA*)
Missouri League for Nursing (*MLN*)
Missouri Hospital Association (*MHA*)

573-526-5686
573-636-5659
573-636-4623
573-635-5355
573-893-3700



Number of Nurses Currently Licensed in the State of Missouri

As of April 29, 2009

Profession	Number
Licensed Practical Nurse	24,183
Registered Professional Nurse	88,943
Total	113,126

Schedule of Board Meeting Dates Through 2010

June 2-5, 2009
September 9-11, 2009
December 2-4, 2009
March 3-5, 2010
June 2-4, 2010
September 8-10, 2010
December 1-3, 2010

Meeting locations may vary. For current information please view notices on our website at <http://pr.mo.gov> or call the board office.

If you are planning on attending any of the meetings listed above, notification of special needs should be forwarded to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 or by calling 573-751-0681 to ensure available accommodations. The text telephone for the hearing impaired is 800-735-2966.

Note: Committee Meeting Notices are posted on our web site at <http://pr.mo.gov>

Miscellaneous Bills

Representative David Sater (Republican–District 68) filed House Bill 37. It would add medical practitioners providing services at a summer camp to the list of health care providers for whom the State Legal Expense Fund is available for payment of certain claims against a provider.

Representative Ellen Brandom (Republican–District 160) filed House Bill 196. It would establish the requirements for health care providers to seek a surrogate to make health care decisions for a patient who is incapacitated.

A number of bills were filed pertaining to patient safety and/or staffing ratios.

Your Role in the Legislative Process

We urge you to study all facets of the issue being considered and know your facts. Be able to tell your legislator what impact a bill will have on his or her constituents. Know the opposing viewpoint. Every issue has two sides.

As a licensed professional, you do have a voice in shaping the future of health care. You can meet with, call, write or e-mail your legislators. Let your legislators know how to reach you, your area of expertise and that you are willing to give them information on issues related to nursing. You can find information about the status of bills and how to contact legislators at <http://www.moga.state.mo.us>.

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- We can promote safe practice through an expeditious discipline process, while ensuring protection of due process for all parties.
- We can decrease the current monetary and regulatory burden for the nurse. The nurse licensure compact removes some of the licensure-related obstacles to assuring accessible, quality, cost-effective health care to rural and under-served populations.
- The Missouri State Board of Nursing has already calculated the fiscal impact on licensure renewal revenue projections through fiscal year 2013. We would not have to raise licensure fees to implement the compact. The positive economic impact is greatest for the nurses who would be able to carry only one license and practice in multiple states at no additional costs. There is an economic gain for employers who are able to move personnel, without concern for costs of licenses.
- The premise for the model is that current licensure requirements are essentially the same from state to state. **It does not interfere with states defining scope of practice in their own unique ways; it ONLY defines the requirements to hold a license and it requires a nurse to comply with the practice laws in the state(s) where they practice.** An individual that does not meet the uniform licensure requirements will be issued a **SINGLE STATE LICENSE**.

Supporters

- American Organization of Nurse Executives (AONE)
- American Nephrology Nurses' Association's (ANNA)
- American Association of Occupational Health Nurses, Inc (AAOHN)
- American Association of Poison Control Centers, Inc (AAPCC)
- Air & Surface Transport Nurses Association (ASTNA)
- American Telemedicine Association
- Association of Camp Nurses
- Case Management Leadership Coalition
- Center for Telemedicine and E-Health Law
- Citizens Advocacy Center (CAC)
- Correctional Medical Services
- Disease Management Association of America
- Emergency Nurses Association (ENA)
- Missouri Association of Licensed Practical Nurses (MOSALPN)
- Missouri Correctional Nurses Association
- Missouri Hospital Association (MHA)
- Missouri League for Nursing (MLN)
- Missouri Nurses Association (MONA)

- Missouri Organization of Nurse Leaders (MONL)
- Several state nurses associations, including Arkansas, Arizona, Delaware, Iowa, Maryland, Nebraska, North Carolina, Texas and Utah
- U.S. Department of Commerce, which supported the NLC in speech to the American Telemedicine Association in 2003 and formally recognized NLC in its report to Congress titled *"Innovation, Demand and Investment in Telehealth"*

We will update you on the status of the nurse licensure compact bill in the next issue of the newsletter.

Frequently Asked Questions Regarding the National Council of State Boards of Nursing (NCSBN) Nurse Licensure Compact (NLC)**What is the mutual recognition model?**

The mutual recognition model of nurse licensure allows a nurse to have one license (in the nurse's state of residency) and to practice in other states, as long as that individual acknowledges that he or she is subject to each state's practice laws and discipline. Under mutual recognition, practice across state lines is allowed, whether physical or electronic, unless the nurse is under discipline or a monitoring agreement that restricts practice across state lines. In order to achieve mutual recognition, each state must enter into an interstate compact, called the Nurse Licensure Compact (NLC).

ADMINISTRATIVE**What is an interstate compact?**

"An interstate compact is an agreement between two or more states established for the purpose of remedying a particular problem of multistate concern." (*Black's Law Dictionary*)

How is the NLC administered?

A separate body composed of the participating state board of nursing administrators in charge of that state's compact operations is called the Nurse Licensure Compact Administrators (NCLA).

How does the NLC get implemented?

In order for a state to join the NLC, state legislators or regulators must enact the interstate compact into state law or regulation. The NCSBN Delegate Assembly set out to accomplish this beginning in 1997, and drafted an outline called *Strategies for Implementation of the Mutual Recognition Model of Nursing Regulation*.

Does enactment of the NLC affect a state's current Nurse Practice Act?

Enactment of the NLC does not change a state's Nurse Practice Act in any way. The NLC gives states additional authority in such areas as granting practice privileges, taking actions and sharing information with other NLC states.

How do these rules and regulations developed by the NLCA provide authority in the individual NLC states?

The NLC is a legal contract between states that enables nursing practice across state lines. In each state that adopts the NLC, the NLC is an additional statutory layer above the individual state's Nurse Practice Act, which remains in place. The NLCA develops rules and regulations to administer the compact, and then individual state boards of nursing in the NLC adopt the rules. If an individual state refuses to adopt the rules the NLCA develops, that state would be in violation of the NLC contract and thus could lose the right to belong to the NLC.

What is the key to smoothly implementing the NLC in my state?

It is important that rule-making processes to implement the NLC be clearly spelled out in the legislation, and that proposed implementation regulations be developed simultaneously with that legislation. The NLCA has drafted model rules that have been adopted through each NLC state's open and public rule-making processes, as set forth in each state's Administrative Procedures Act. States should plan 6 months–1 year between legislation passing and fully implementing the NLC.

LEGISLATIVE**What is meant by multistate licensure privilege?**

Multistate licensure privilege means the authority to practice nursing in any compact state that is not the state of residency. Additional license is not granted for this authority.

What determines primary residency for licensure purposes in the NLC?

The Nurse Licensure Compact Administrators (NCLA) defined primary residence in the compact rules and regulations. Sources used to verify a nurse's primary residence for the NLC may include, but are not limited to, driver's license, federal income tax return or voter registration.

Why was residency, not practice location, used for determining jurisdiction?

During the development of the NLC, NCSBN carefully examined two options: (1) linking of licensure to the "state of residence"; and (2) linking licensure to the "state of practice" and concluded that it was preferable for the state of residence to be the state of licensure. This decision was made specifically to enhance public protection while retaining state-based authority and reducing administrative burden.

Although the traditional licensure system was built upon state of practice, issuing a single license to practice in multiple states under the mutual recognition model forced a reconsideration of that tradition. Licensure through state of practice was rejected for a number of reasons:

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- Determining the state of practice is difficult in this era of working for multiple employers, at multiple sites across state lines and through telenursing.
- Tracking a nurse in the event of a complaint/investigation is more readily accomplished with a residence link (address) than an employment/practice link.
- Linking licensure with practice can be problematic for nurses not currently employed or moving in or out of the workforce.
- Defining practice as occurring both where the nurse is and where the patient is, for purposes of identifying the “home” state, is difficult because there could be more than one state of practice.

Since maintaining state-based authority was a critical objective in developing the NLC, it was determined that changing the residency requirement would have drastically changed the substance of the NLC from an instrument to facilitate nurse mobility through mutual recognition of licensed nurses to essentially a national practice act.

Why is an individual living in a NLC state limited to one license among the NLC states?

- One license reduces the barriers to interstate practice.

- One license improves tracking for disciplinary purposes.
- One license promotes cost effectiveness and simplicity for the licensee.
- One license acts as an unduplicated listing of licensed nurses, for planning and disaster preparedness.
- One license facilitates interstate commerce.

Can an individual hold both an RN and an LPN/VN license type in the NLC?

Yes, the mutual recognition model provides for this authorization: one license per each license type if permitted by the state of residency.

PRACTICE

Does the NLC reduce the level of a state's licensure requirements?

No. Under the NLC, states continue to have complete authority in determining licensure requirements and disciplinary actions on a nurse's license per the state's Nurse Practice Act.

DISCIPLINE

How does the NLC address the varying scopes of nursing practice as authorized by each NLC state?

The NLC provides that the nurse is held accountable for complying with the nursing practice laws and other

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regulations in the state where the patient is located at the time care is rendered. This accountability is similar to the motor vehicle driver (driver's license compact) who must obey the driving laws in the state where he or she is driving. In fact, all nurses are accountable for this, it is not unique to the NLC.

Does the NLC affect the authority of the primary state of residency to discipline?

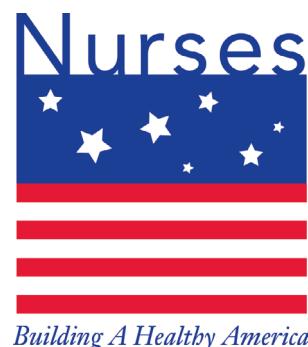
No. As provided in the NLC, both the state of licensure (“home/residency state”) and state where the patient is located at the time the incident occurred (“remote/other NLC state”) may take disciplinary action and thus directly address the behavior of the nurse licensed through the NLC. The NLC actually enhances the state of residency's ability to discipline; through ready exchange of investigatory information, the state of residency has the most current and accurate information in order to better determine the appropriate course of action in disciplinary cases.

How do violations get reported and/or processed in the NLC?

Complaints in a nonresidency compact state concerning a violation that occurred would be processed in the state the violation was reported to have occurred, and the action taken would also be reported to the state of residency. For example, the state of practice may issue a cease and desist order to the nurse, and the state of residency may also take disciplinary action against the license of that nurse. Many states choose to investigate the complaint in the state in which the incident occurred and transfer that information to the licensing board for action, so it is taken on the licensee only once.

NCSBN has developed a coordinated licensure information system called Nursys™ to enable the sharing of information. All information involving any action is accessible to all NLC states. Additional information in Nursys™ is also available to participating noncompact states. Final actions on nurse licensure that are publicly available by all participating states in Nursys™ will also be

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Building A Healthy America

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available to the public for a small fee. For more information, visit www.ncsbn.org in the Nursys™ License verification section.

What is meant by "home" state or state of residency/licensure action?

The home state is the state in which the nurse declares residency and receives the license that allows participation in the NLC. Only the state of residency/licensure can take action against the license. Action by that state means any administrative, civil or criminal penalty permitted by that state's laws which is imposed on a nurse by the board of nursing or other authority in the state of residency/licensure. This includes actions against an individual's license.

What is meant by remote state action?

The remote state is the compact state that is not the state of residency/licensure and represents a new authority granted to the participants of the NLC. Remote state action is any administrative, civil or criminal penalty imposed on a nurse by a remote state's licensure board or other authority. This includes actions against an individual's multistate licensure privilege to practice in the remote state. For example, under the NLC, authority is given to issue cease-and-desist orders by the remote state or the remote state's licensing board.

Must the state of residency/licensure notify other NLC states of disciplinary actions?

Yes, this is accomplished by reporting information to Nursys™, the coordinated nurse licensure database.

Does every complaint received by the NLC state need to be shared with the state of residency/licensure? Do the results of these complaint investigations need to be shared with the state of residency/licensure?

The nonresidency/practice NLC state will report to the Nursys™ database any actions taken. The nonresidency/practice NLC state will also report any significant current investigative information yet to result in an action by that state. Nursys will be used to notify the state of residency/licensure of any significant investigative information and any actions on the privilege to practice.

Concerning complaints, what information is reasonably necessary to share with all NLC states?

All NLC states share information regarding who to contact for information regarding significant investigative information relevant to a current investigation. It is recognized that many complaints are not substantiated and reporting these would increase workloads and may be nonproductive.

How does the NLC affect individuals participating in alternative programs?

Nothing in the NLC overrides a party state's decision that participation in an alternative program may be used in lieu of licensure action, and that such participation remains nonpublic if required by the laws of the state of residency/licensure. All NLC states must require nurses who enter any alternative programs to agree not to practice in any other NLC state during the term of the alternative program without the prior authorization from that NLC state.

Does a board of nursing have the authority to deny licensure by endorsement to an applicant who has had discipline action in another state?

Yes. The licensing authority in the state where an application is made may choose not to issue a license if the applicant does not meet the qualifications or standards for granting a license.

Does the NLC affect states' collective bargaining rights/facilitate strikebreaking?

The NLC does not impact the statutory authority at the federal or state level for collective bargaining. There is little or no practical difference in the ability of employers to bring in licensed nurses from other jurisdictions under the NLC or by endorsement.

NCSBN does not believe that the NLC facilitates strikebreaking. However, to the extent an individual state believes the compact might do so, language has been included in Missouri's proposed legislation explicitly stating that the NLC does not supersede any existing state labor laws.

As a matter of public policy, boards of nursing do not consider where or in what circumstances a qualified nurse plans to practice. This is true of traditional state licensing; it is also true of nurses practicing under the NLC. The reality is that the turnaround time to grant a temporary permit or temporary license is a matter of days in most states. The initiation of a strike is typically an event of last resort that mandates prior notice to affected facilities. There is time for contingency planning.

Does the NLC impact how disciplinary cases are handled?

All boards of nursing are mandated by law and committed to providing fair and objective resolution of disciplinary cases. The Nurse Practice Acts of most states (including non-NLC states) currently authorize boards of nursing to take action based upon action in another state. This means that a nurse who has his or her license disciplined in one state is likely to also face action in all

other states of licensure. Multiple actions are possible, and likely, under the traditional regulatory scheme of single state licensure.

When two or more states are involved, boards in the NLC rely on the disciplinary determination made by another board just as boards do in non-NLC states.

LICENSURE**Does enactment of the NLC affect the individual licensee?**

The individual RN or LPN/VN residing in an NLC state can practice in all the party states by virtue of the multi-state privilege to practice, unless there is some restriction placed on the license, and thus not granting the multi-state privilege. The individual RN or LPN/VN residing in a non-NLC state will continue to be licensed in individual state(s).

If a nurse lives in an NLC state and obtains a license in a non-NLC state, must the nurse give up the license from the NLC state?

No. The license from the NLC state where the nurse resides allows the nurse to practice in all states party to the NLC. The license obtained from the non-NLC state allows practice in just that state.

Is there a time requirement for applying for a new license in a new state of residency (an NLC state)?

According to the NLC rules and regulations, a nurse changing primary state of residence from one party NLC state to another, may continue to practice under the former state license if (including the NLC privileges) processing of the nurse's new licensure application in the new state of residency does not exceed 30 calendar days.

How will an employer know that a nurse's NLC license is no longer valid?

The burden is on the employer, as it is under single-state licensure models, to verify licensure at all significant times of change in status of nurses they employ. Under the NLC, these significant times include any time a nurse changes state of residence. In addition, they can check Nursys™ at www.nursys.com.

How do I know if a nurse is practicing under a single state license or under a multistate privilege?

You may access the particular state's website for the information or you may view the nurse's wallet card for the distinction.

The status of the nurse's license will be available on the State Board of Nursing's website, Nursys and on the wallet card.

What about nurses employed by the military or federal government?

A federal government/military nurse practicing exclusively in federal or military systems need only have one license from any state or territory per U.S. federal government/military policy. A federal or military nurse who also practices in a civilian health system is bound by the Compact law and rules.

A federal/military nurse who has proof of residency in a Compact party state may be issued a Compact license with a multi-state practice privilege. A federal/military nurse who does not have proof of residency in a Compact party state may be issued a single-state license regardless of where the nurse is residing. A military/federal nurse may not hold a multi-state license from more than one Compact state at a time.

PRACTICE**How do nurses practicing in NLC states obtain ongoing access to practice-related information, including current board of nursing policies?**

Nurses should have access to this information through the board of nursing in their residency/licensure state. The NLC does not interfere with this procedure.

Making current and timely information regarding nursing practice available to nurses is an ongoing challenge. Many boards utilize technology to maintain Web sites and post practice-related information, including board policies. Boards of nursing also utilize newsletters and other communication activities.

Members of the NLCA have committed to making practice-related information readily available on their state Web sites and would welcome input on how to improve this information-sharing process.

How do you know who is practicing in your NLC state?

Regardless of the licensure model in a state, it is not possible to know who is practicing in your state at any given time. Any lack of reliable information about nurses practicing in a state is neither created nor solved by the NLC. A non-NLC state does not have a complete accounting of all nurses practicing in its jurisdiction; it has information only on those nurses licensed in its jurisdiction. For example, a nurse may be licensed in multiple non-compact states simultaneously.

Thousands of nurses working in the military, in federal facilities and for federal agencies practice on the basis of being licensed in any state anywhere and then are allowed to practice in any federal setting. This is the concept of mutual recognition in practice.

APRN**Are advanced practice registered nurses (APRNs) included in the NLC?**

No, not in the NLC, but in 2002, the NCSBN Delegate Assembly adopted the separate APRN Compact model legislation and implementation guidelines. Advanced practice nurses were not included in the original NLC (in 1999) because of the wide variability in the regulation of advanced nursing practice needed special consideration.

What is the status of the APRN Compact?

Similar to the existing NLC for recognition of RN and LPN licenses, the separate APRN Compact offers states the mechanism for mutually recognizing APRN licenses/authority to practice. This is a significant step forward for increasing access and accessibility to qualified APRNs. A state must be an operational member of the NLC for RNs and LPNs before entering into the APRN Compact. A state must adopt both compacts to cover LPNs/RNs and APRNs for mutual recognition.

The Uniform APRN Licensure/Authority to Practice Requirements, developed by NCSBN with APRN stakeholders in 2000, establishes the foundation for this APRN Compact.

FOR MORE INFORMATION

Please visit www.ncsbn.org in the Nurse Licensure Compact section to access the NLC and APRN Compacts, enabling language, rules and map of states that have implemented the NLC.

QUORUM OF THE BOARD

Board members are appointed to the Board by the Governor with advice and consent of the Senate when a vacancy occurs either by expiration of a term or resignation of a Board member. There are nine Board member slots; five of whom must be registered professional nurses, two must be licensed practical nurses, one undesignated member, and one member a voting public member. Every appointment except to fulfill an unexpired term shall be for a term of four years, but no person may be appointed for more than two consecutive terms. The board is entrusted with the duty of ensuring that the RNs and LPNs licensed in Missouri comply with Chapter 335 thus creating an atmosphere of safe and effective nursing care in the interest of public protection. The members of the Board, along with its staff and general counsel are entrusted with the legal responsibility to see that the provisions of the law are carried out effectively, in addition to serving as a policy making and planning group. When administering the NPA and establishing policy, the Board considers the licensee, the patient, the community, the State of Missouri and programs of professional and practical nursing. The Board's primary role is governance while the staff's primary role is management.

The Board of Nursing had to cancel their March 2009 Board meeting due to lack of a quorum. All disciplinary and probation violation hearings have been rescheduled to the Board's June meeting. As soon as the Board has a quorum, the Board will conduct a series of conference calls to conduct business.



Investigations Corner

Nurse Imposters

**Authored by Quinn Lewis,
Investigations Administrator**

State Boards of Nursing around the country have seen a rise in the number of individuals representing themselves as nurses. These individuals falsify their credentials and they obtain employment as a nurse.

Nurse imposters are present in every state, not just Missouri. This is a challenge that faces all State Boards of Nursing. Nurse imposters pose a significant threat to public safety. These individuals put patients at risk by performing procedures that they are not qualified to do. These individuals may be practicing in your hospital, nursing home or doctor's office without a license.



Lewis

The Board's jurisdiction over a nurse imposter is limited. The Board only has authority over a person who is a licensed nurse in this state. Therefore the Board's powers are limited when it comes to nurse imposters, because they do not possess a valid Missouri nursing license. When the Board learns of a situation that involves an unlicensed individual who is representing themselves as a nurse, the Board will contact the employer and obtain as much information as possible to establish the identity of the imposter. The Board will add that individual's name to its data base for tracking purposes. The Board will then send a letter to the individual, informing them to immediately cease and desist any functions relative to nursing. The Board will then refer all information to local law enforcement for possible prosecution. Impersonation of a nurse is a class D felony in the state of Missouri.

Employers should do a careful inspection of a prospective employee's nursing credentials. Employers should keep an eye out for red flags that would indicate that further investigation may be warranted. The following is a list of indicators that employers should look for.

- Failure to provide a license. An individual provides several excuses why he/she can not provide the employer with his/her actual license.
- Provides a photo copied license. The individual will provide the employer a copy of a nursing license, not the original.
- When pressed on the matter he/she continues to make excuses and does not provide an original certificate or laminated copy.
- Employers should pay attention to numerous errors and lack of judgment that would be considered basic nursing for someone with an appropriate level of education and experience.

Recently, I was contacted by one of our licensure staff who informed me that there was an employer attempting to verify a license of a Catherine M. Connor. The employer said that there was something "odd" about the credentials of this individual. The employer said that Connor submitted a photo copy of a Missouri nursing license. The employer stated that she informed Connor that she did not accept a photo copy of a license. Connor told the employer that she had lost the original and she hadn't replaced it yet. I was then informed that the license number she was asked to verify was not assigned to Catherine M. Connor.

The name on the license to be verified was Catherine M. Connor. The person that the license number belonged to in the Board's data base was a Katherine spelled with a "K". This Katherine also had a different last name, DOB and SSN.

I then contacted the employer and asked that she fax all documents that the potential employee had filled out when she applied for the RN position. The information in the documents revealed that the Catherine Connor who was attempting to gain employment was an individual who was listed as a Nurse Imposter in the Board's data base. Ms.

Connor has managed to obtain steady employment for the past 15 years in the State of Missouri by producing fraudulent credentials.

Ms. Connor's history began in 1994. Ms. Connor attended nursing school in the state of Virginia where she took the NCLEX and failed it the first time. Ms. Connor took the NCLEX a second time and she passed it. However, she was denied licensure due to an extensive criminal history related to fraud.

Ms. Connor then moved to Missouri where her husband held a valid Missouri nursing license. Ms. Connor altered her husband's licensure card and obtained employment at a well known hospital in St Louis. Ms. Connor went undetected at her place of employment for ten years before she was discovered. Note that Ms. Connor's deception was not discovered due to questions about her nursing license, it was due to other manufactured credentials.

After Ms. Connor was discovered at her last job, she managed to obtain several additional nursing positions using fraudulent credentials. It appears that Ms. Connor avoided employment that involved direct patient care. Her employment mostly centered around education and supervisory positions.

It is very disturbing that Ms. Connor could manage to go undetected for so long and continue to gain employment by deceptive means. An employer must be willing to do a thorough check of credentials prior to hiring a nurse. One cannot assume that everyone is who they claim to be. I mentioned several indicators of deception earlier in this article that should send up a red flag when verifying nurse credentials. Ms. Connor revealed two of those indicators that initiated further inquiry by the last potential employer.

It was also discovered that Ms. Connor had stolen a co-worker's laminated license, made a copy of it and transposed her name on the card for future use. While speaking to the nurse who had her card stolen, she revealed that she kept her card in her desk drawer at work, unsecured. She could not believe that Ms. Connor was not a nurse. I would also like to mention that Ms. Connor was reported to law enforcement when she was first investigated back in 2004. The case was never prosecuted by local law enforcement. In their defense, this is not a crime that they deal with very often, so nurse imposter cases tend to get pushed to the side.

In closing, nurse imposters are out there. They are clever and hard to detect, because most of them are very familiar with the duties and functions of a nurse. We all have to work together to make sure that the public is protected.



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Discipline Corner

Professional Boundaries

**Authored by Janet Wolken, MBA, RN
Discipline Administrator**

Nursing is a trusted profession. A nurse cares for people that are vulnerable due to a physical or mental ailment. The help that a nurse provides is sometimes technical such as working with ventilators and chest tubes or very personal when inserting urinary catheters and bathing a patient. A nurse may have a very short contact with a patient such as days (in a hospital) or a longer term relationship with a patient such as months or years (in rehabilitation, long term care, or home health). Within this relationship a nurse is often entrusted with personal information from the patient in regards to family and their hopes and fears regarding their illness. Also a time in every nursing career will occur when the nurse already knows the patient from the community where they live. The nurse must leave the patient information and relationship in the work environment. A nurse in the work environment must always be concerned about what is best for the patient and respect the patient's dignity. A nurse must maintain professional boundaries.

A boundary violation occurs when a nurse becomes over involved with a patient. The nurse gives her/his cell phone number or home phone number to a patient so they can call if they need to talk. A nurse offers a patient a place to live when they are discharged because they have no where else to go. A nurse takes a patient on an outing or buys them things with their personal monies. A nurse enters into an intimate or business relationship with a patient. Each of these behaviors represents a time when a nurse has become over involved with a patient and may no longer be able to be therapeutic with the patient.

Boundary violations may also take the path of being over involved with a patient to the extent that a nurse will accept or ask for favors from a patient. A nurse accepts money from a patient. A nurse accepts gifts from a patient. A nurse secures a loan through a patient. A nurse discusses personal problems with a patient. These violations may cause the patient to be concerned that if they say "no" to the nurse that the nurse will no longer provide proper care for them or may even harm them. These feelings are not therapeutic for the patient and may cause harm to the patient.

It is never appropriate to have sexual contact, use offensive language, or tell jokes of a sexual nature with a patient. This conduct involves the crossing of professional boundaries.

If a nurse begins to have non-therapeutic feelings for a patient the nurse should become concerned about boundary violations. To avoid boundary violations keep nurse/patient relationships professional and in the work place. If you feel a relationship is reaching the edge of appropriate boundaries request a co-worker to assist with the care of the individual or discuss the situation with a supervisor.

If you wish to learn more about professional boundary issues the National Council of State Boards of Nursing has a brochure entitled Professional Boundaries that is available at https://www.ncsbn.org/Professional_Boundaries_2007_Web.pdf. They also have a continuing education course that may be found at <http://www.learningext.com/products/generalce/boundaries/boundariesabout.asp>



Wolken

Licensure Corner

**Authored by Angie Morice
Licensing Administrator**

Name and Address Changes Rose Sharply in February

This office made 6,071 name and address changes between February 12, 2009 and March 11, 2009. The increase can be attributed to the RN Renewal period. Renewal notices were mailed starting February 1, 2009. Many nurses contacted us when they discovered they did not receive their renewal notice only to learn that the Board did not have their most current contact information. In order to receive timely communication (renewal notices, newsletters, etc.) it is important to keep the Board advised of name and address changes as they occur.

Please notify our office of these changes in writing. A change form is available in this newsletter or on our website. The request must include your name, license number, the changes and your signature. Methods of submitting name and/or address changes are as follows:

- By faxing your request to 573-751-6745 or 573-751-0075.
- By mailing your request to Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102



Morice

324.010 No Delinquent Taxes, Condition for Renewal of Certain Professional Licenses

All persons and business entities renewing a license with the Division of Professional Registration are required to have paid all state income taxes and also are required to have filed all necessary state income tax returns for the preceding three years. If you have failed to pay your taxes or have failed to file your tax returns, your license will be subject to immediate suspension within 90 days of being notified by the Missouri Department of Revenue of any delinquency or failure to file. If you have any questions, you may contact the Department of Revenue at 573-751-7200.

RN renewals with "yes" answers

RN's who answered "yes" to any questions on the renewal will need to submit a notarized explanation and supporting documents to the Board. If you answered "yes" to any of the questions on the renewal and have not already submitted the proper paperwork, you will receive a letter in the mail asking for your explanation and supporting documents to your answer. It is important that you respond to this letter. Failure to do so may result in an investigation and possible discipline against your license.

Contacting the Board

In order to assist you with any questions and save both yourself and our office valuable time, please have the following information available when contacting the Board:

- License number
- Pen and paper



The Biggest Misconception

Authored by Mikeal R. Louraine, B.S., J.D.
Senior Legal Counsel

At one of the first Board meetings following my being hired by the Board, a student asked the Board, "what is the biggest misconception that nurses have about the Board?" Being so new, I didn't feel qualified to respond. One of the Board members responded that they felt that the largest source of confusion stemmed from confusing the role of the Board with the role of the Missouri Nurses' Association, or MONA. While I certainly agree that is a source of many questions, I have, after three years now of being employed by the Board, reached a different conclusion. I believe the biggest misconception about the Board lies in the disciplinary options available to the Board. It seems that the average licensee has no idea that the Board has options available other than revocation. Granted, revocation of a license is an option that the Board can exercise. However, it is an option that is used sparingly and only after much deliberation. Every time I read an investigation that includes a statement from the nurse, though, they almost without exception state that the Board should not revoke their license for whatever violation they may, or may not, have committed. This tells me that the licensee does not understand the multiple options available to the Board. I thought I would use this space to review the levels of non-disciplinary and disciplinary actions that are available to the Board.

The first option is what the Board refers to as an 'NFA' or 'no further action'. In these cases, the Board feels that either the conduct reported does not constitute a violation



Louraine

of the Nursing Practice Act (NPA) or the evidence is insufficient to prove that the nurse committed an NPA violation.

The next option is a 'letter of concern'. When the Board feels that the licensee may have technically violated the NPA, but the violation is not serious enough to warrant discipline or if the Board believes the NPA has been violated but the evidence is not likely to hold up in a hearing, a letter of concern is issued. The letter advises the nurse that the Board is concerned that an NPA violation may have occurred and that the licensee should take necessary steps to avoid a repeat of the incident that led to the complaint.

An NFA and a letter of concern are considered non-disciplinary. In both cases, the results are not available to the public. Pursuant to §335.068 RSMo, the complaint and the resulting investigation are now considered a 'sealed' record. A 'sealed' record will not be disclosed to the public, other Boards of Nursing or anyone without the licensee's express, written permission. The nurse need not reveal the complaint on any future renewals with the Missouri Board and there is no public record of the complaint and decision of the Board.

Any license actions from this point on are considered discipline and are public information. The fact that a license has been disciplined and the Settlement Agreement or Order that imposed the discipline against the license is considered a public record.

The lowest level of discipline that the Board can impose against a license is a censure. A censure is a notation on the license that the licensee violated the NPA. There are no restrictions or conditions attached to the censure. The censure is, technically, only in effect for one day, but, like all license actions, stays on the licensee's record forever.

The next level of discipline is probation. The Board can place a license on probation for a period of from one day up to five years. The Board can also impose conditions and

restrictions which are appropriate to the nature of the NPA violation. For example, if the violation is a practice error; documentation, time management, etc., the Board can require the licensee to take continuing education classes in a specific area or subject. If the violation involves alcohol addiction or abuse of controlled substances, the Board can require chemical dependency evaluations, random drug screening and restrict access to controlled substances. All licensees on probation are required to advise their employer of their probationary status with the Board and provide their employer with a copy of the Board Order or Settlement Agreement. They are also required to have their employer provide the Board with, at least, quarterly evaluations of their job performance.

The next level up is suspension. The Board can suspend a license for a period of one day to three years. When a license is suspended, the licensee cannot practice nursing in the State of Missouri. At the end of the suspension period, if the licensee is otherwise eligible, the license will be returned to active status. Suspension is often used in combination with probation. For example, a licensee could be suspended for a period of six months to be followed by probation for a period of three years.

The final level of discipline is revocation. The licensee loses their license and cannot practice nursing in the State of Missouri. In order to get re-licensed, the licensee must wait one year from the date of revocation and re-apply to the Board. That application is subject to approval by the Board and may include the re-taking of the NCLEX.

While the Board, and your employers, certainly encourages you to avoid violating the NPA, a violation is not the end of your career as a nurse. Every disciplinary case is looked at individually. The Board takes a great deal of time reviewing every case and strives to make the best decision in each case. The imposition of discipline against a license is a very serious undertaking and is not taken lightly by the members of the Board.

Education Report

Authored by Bibi Schultz, RN MSN,
Education Administrator

The year 2008 has been an eventful time for nursing education in Missouri. Currently 46 Programs of Practical Nursing (PN), 35 Associate Degree Nursing (ADN), 23 Baccalaureate of Science in Nursing (BSN), and 1 Diploma Nursing program are approved by the Missouri State Board of Nursing (MSBN) to teach nursing in this state.

In 2008 the MSBN board office received nine letters of intent for establishment of new nursing programs in Missouri. Letters of intent are to be submitted at least three months prior to submission of a new program proposal and the application fee. Upon MSBN full board acknowledgement of each letter, the intent for



Schultz

establishment of a new program is electronically communicated to nursing programs in Missouri. Program comments regarding such intents are strongly encouraged. MSBN board members give serious consideration to submitted comments/concerns regarding new program approvals.

The MSBN board office received one PN program proposal as well as six proposals for establishment of ADN programs in Missouri in 2008. All program proposals were reviewed. During the December 2008 MSBN full board meeting Carthage Technical Center in Carthage, MO received initial approval to start a new PN program. In 2009 new program approval processes for at least four other nursing programs are in progress. MSBN initial approval for all new programs is contingent upon confirmation of proposal compliance during subsequent site surveys conducted approximately 30 days prior to projected program start.

Upon graduation and NCLEX performance assessment of the first class an initial-to-full approval visit is conducted. A program may gain full approval, remain on initial approval for an additional year or lose MSBN approval. MSBN board staff plans and conducts initial, initial-to-full approval, routine (5-year approval), relocation and focused (follow-up of complaints) site visits. Each nursing program in Missouri is surveyed at least once in each 5-year approval period. MSBN board members and/or adjunct surveyors accompany board staff during such visits. In 2008 a total of 41 on-site program visits were conducted. Out of those 29 were routine 5-year surveys, 4 initial-to-full approval, 4 relocation surveys, 2 focused visits, 1 initial approval and 1 conditional-to-full approval survey. A total of 10 visits were conducted at BSN, 16 at ADN and 15 at PN programs. 39 site surveys have been scheduled for the year of 2009 so far. Current and past NCLEX pass rates as well as current MSBN approval status for all Missouri nursing programs may be accessed through the MSBN website at pr.mo.gov/nursing.asp, under Schools of Nursing.

The Nurses Role in Documentation and Reimbursement

by: **Sharon Canariato, MSN, MBA, RN**

CE OFFERING

1.5 CONTACT HOURS

This offering expires in 2 years:
November, 2010

The goal of this continuing education offering is to provide information on documentation and reimbursement.

The objectives of this article are:

1. List the rules/laws/agencies that regulate health care billing and the consequence for non-compliance
2. Outline appropriate nursing documentation and its relationship to hospital reimbursement
3. Identify those scenarios not reimbursed by CMS and how a nurse's documentation may assist

The nurse through charting holds one of the keys to improved reimbursement for the hospital. There are several key charting conditions that must be accurate. Most of the scenarios discussed in this article are applicable to the hospital in general; some are specific to the Emergency Department while others pertain to observation patients. The following recommendations are made in general, as they are good nursing practice. According to Bonnie Salvetti, RN, Special Projects Coordinator from Memorial Hospital of Carbondale, "A hospital is a business. The nurse's role in documenting the care that they give and when they give it impacts the revenue the hospital receives. Hospitals can then in turn hire more staff, purchase equipment and update technologies." Of course accurate documentation is a joint effort between the hospital and

the nurse. The nurses charting should accurately reflect her practice and the hospital should allot sufficient time for the nurse to achieve this objective.

We have always heard during our nurses training that, 'If it wasn't documented, it wasn't done'. While the practice of thorough documentation is in the best interest of patient care and good nursing practice, it also holds true in the case of hospital reimbursement. There are many types of reimbursement methods but hospitals typically receive revenue through accurate billing. Documentation in the medical record must be accurate and thorough to be reflected correctly in the bill. This will insure the proper amount of reimbursement to the hospital. Salvetti goes on to say, "Nursing documentation affects three major areas. First, documentation drives observation dollars. Then the documentation of tests, treatment and services improves reimbursement. And finally, the accurate documentation of medication administration has a direct impact on returns."

A common source for overlooked revenue is associated with missed charges for services and procedures that were completed but never documented and therefore unable to be billed. Improving hospital reimbursement is contingent upon adequate staff education. Nurses in particular need to understand the essential patient documentation skills, which are necessary clinically, legally and from a reimbursement perspective. Salvetti states, "The most important factor for a nurse to document is every event, intervention or change in patient condition."

Correct documentation will capture the correct level of care that each patient receives. If all possible charges are captured, the amount of revenue a hospital receives will be increased thereby justifying future purchases and staff increase. Nurses can greatly help an institution by documenting in a consistent, thorough and compliant manner. In the long run nurses would reap the benefit by increasing the revenue in the facility in which they work. According to Contino (2000), "The most common error occurs when hospitals don't code every facet of patient

care. Nurses must document everything they do for a patient. They must write completely and legibly. If not, they may cost the institution revenue." (p. 15)

Hospitals receive money from many different payer sources. There are several establishments that pay insurance claims in the state of Illinois. Medicare is one of the larger payers of health care claims. According to the Centers for Medicare and Medicaid Services (2008), Medicare is a federal insurance program that was created in 1965 for person's aged 65 and over regardless of income or medical history. In 1972 Medicare extended coverage to include those people less than 65 years of age who had disabilities. According to the Kaiser Family Foundation (2008), there are 1,752,798 Medicare enrollees in the state of Illinois. Another payer that is a joint federal and state mediated insurance program is Medicaid. Medicaid provides payment for health care services including long-term care and for people with qualifying low income. Lastly, there are private insurances. The US Census Bureau (2008) defines private insurance as non-government coverage provided through an employer or union or purchased by an individual from a private health insurance company. Examples of such agencies include but are not limited to: Blue Cross Blue Shield, Cigna, Aetna and numerous others.

Now that the agencies that pay hospital bills have been identified, it is important to understand that there are other organizations and public acts that create the rules and regulations of health care billing. Insurance claims must be submitted in a particular manner with certain information. Many different organizations and laws establish the requirements for billing. These various entities include but are not limited to:

- **False Claims Act (FCA)**—This Act provides a legal tool to counteract fraudulent billings turned in to the Federal Government.

The Nurses Role in Documentation continued on page 10

The Nurses Role in Documentation continued from page 9

- **Civil Monetary Penalties (CMP)**—The Social Security Act authorizes the secretary of HHS to seek civil monetary penalties (CMPS) and assessments for many types of conduct such as presenting claims to a Federal health care program that the person knows or should know is for an item or service that was not provided as claimed or is false or fraudulent
- **Health Insurance Portability & Accountability Act (HIPAA)**—An act created to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes.
- **Emergency Medical Treatment & Active Labor Act (EMTALA)**—The purpose of the statute is to prevent hospitals from rejecting patients, refusing to treat them, or transferring them because they are unable to pay or are covered under the Medicare or Medicaid programs.
- **Stark Physician Referral Prohibition, Anti-kickback Statute**—This statute prohibits physicians who have a financial relationship with an entity from referring their patients to the entity for designated health services.
- **Deficit Reduction Act**—Provides states with flexibility to make significant reforms to their Medicaid programs
- **Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU)**—hospitals must submit quality performance data for all payers, on all 10 required quality measures to receive the full annual payment update. Hospitals that do not participate in RHQDAPU will receive a reduction of 0.4% in the annual payment update.
- **CMS (Centers for Medicare & Medicaid Services) Condition of Payment**—Hospitals are subject to the Terms and Conditions of Payment when providing covered services.
- **The Joint Commission**—An independent, not-for-profit organization, The Joint Commission accredits and certifies health care organizations.
- **Service Line Accreditation (CLIA, ACR, etc.)**—Various agencies certify performance of departments within the hospital.

As rules exist for the mechanism of submitting claims and receiving payment, there must be governing bodies that insure adherence to these regulations. On a federal level, these agencies include: Office of the Inspector General, Department of Justice, Office of Civil Rights,

Quality Improvement Organizations, Hospital Payment Monitoring Program, Comprehensive Error Rate Testing Program, and Medicaid Fraud Control Unit. Private entities also attempt to make sure that regulations are followed. These include The Joint Commission and other surveyors. Additionally, private patients and employers play a role in reviewing their bills, claims and hospital reimbursement. Incidentally, hospitals themselves may perform audits to compare what services were documented in the patient's chart against what was charged in an attempt to identify areas needing improvement.

A new program is being implemented by the Centers for Medicare & Medicaid Services (2008). Recovery Audit Contractors (RAC) is a federal program that consists of Medicare auditors who are paid a percentage of all identified overpayments and underpayments made to a hospital. This program will be implemented in all states by January, 2010. The pilot for the RACs was conducted in California, New York and Florida and lasted three years. By reviewing documentation in patient charts and auditing processed claims and payment, the RACs recovered \$371 million in overpayments made to the hospitals.

As discussed, there are rules and regulations for billing. The "watchdog groups" overseeing compliance of billing and reimbursement always go back to the chart for confirmation of what was billed. Naturally, there are consequences for non-compliance of established billing guidelines if discrepancies are found in the chart versus what was billed. The greatest consequence would be the potential for compromised patient safety and quality of care. Inaccurate or incomplete documentation in the chart could lead to errors and/or to a less than optimal patient outcome. Another implication to the patient for substandard documentation is the possibility that the patient could be overcharged.

The hospital as well can suffer financial penalties. Inaccurate documentation and billing could lead to a reduction or elimination of payment for services. One Illinois hospital studied the documentation of IV start and stop times in the Emergency Department. The result of the audit showed a potential \$400,000.00 loss in charges. The hospital then in-serviced their nurses on the documentation of IV start and stop times. Once the training was complete, a new study realized a 90% improvement in documentation of IV start and stop times.

A hospital may experience even greater ramifications to improper billing due to lacking documentation. Monetary fines could be imposed on the institution. Of great concern is that the potential exists for hospitals to be excluded from federally funded programs such as Medicare and Medicaid for not following guidelines. This would be a serious implication to hospitals if they were no longer able to accept Medicare and Medicaid patients. Other consequences to the hospital could include loss of non-profit status and loss of license. Bad publicity and subsequent loss of patients would be the final result of any of the above actions.

The most basic piece of advice for ensuring accurate documentation is to make sure that all forms or pieces of paper in the chart have the patient's name and account number. If a form does not have the appropriate identifiers, there is no proof that the information on those forms pertains to that specific patient. Additionally, writing the order to admit a patient is very often incomplete. The nurse must include in the order the type of admission. Is the admission inpatient, outpatient, observation, surgical or procedural intervention? To write an order to simply admit a patient to a particular floor or service is insufficient.

The documentation of medication administration is an area where improvements could usually be made. Drug administration services that reflect time are in fact "time based codes". Therefore, documentation should support the billed charges. Remember to sign out all medication that was given. It may seem obvious to you when the medication was given but always remember to include the date and time if it is not clearly notable. Very often the time of day a patient received a medication affects their billing. Also, it is extremely important to document the route a patient received a medication. Frequently a physician will order a medication to be given PO or IV. It is up to the nurse to document the actual route given. The different forms of medication will obviously have different costs. "In documentation of medication administration, remember that along with charting the 5 rights, but then include date, time and length of infusion," states Salvetti.

For example, a patient comes into the ED, the physician orders Morphine 2 mg PO or IVP. The nurse documents that the dose was given at 2000. The RN fails to document the route in which she gave the med. The hospital will not be able to charge for the ED nurse's time in this process.

Intravenous fluids can generate improved revenue provided the documentation is accurate. Typically, documentation for infusion services reflects the substance being infused and the flow rate but that is not enough. It is important to chart the date and time an infusion was

initiated and stopped. The length of infusion can be varied. Some items in some areas of the hospital are chargeable by the minute. An IV that runs for 15 minutes may receive less money than one that lasts for 60 minutes.

For example, a patient was admitted to observation status. An IV was started at 1400. There was no documentation in the patient's chart regarding the IV at all. The hospital then has the potential loss of hundreds of dollars.

With the advent of changes to Medicare reimbursement, nurse's documentation is extremely important, especially on admission. Effective October 1, 2008 the Centers for Medicare and Medicaid Services (2008) will stop paying hospitals for the extra care provided to patients to treat hospital acquired conditions. Medicare finalized a list of types of conditions for which, it will no longer reimburse hospitals at the higher diagnosis-related group rate. This list includes:

- Stage III, IV pressure ulcers
- Fall or trauma resulting in serious injury
- Vascular catheter-associated infection
- Catheter-associated urinary tract infection
- Foreign object retained after surgery
- Certain surgical site infections
- Air embolism
- Blood incompatibility
- Certain manifestations of poor blood sugar control
- Certain deep vein thromboses or pulmonary embolisms

There is an opportunity for nurses to identify conditions that were actually present on admission and not hospital acquired. To accomplish this, a nurse must perform a thorough assessment followed by thorough documentation. Under the policy change, CMS will only pay for the treatment of conditions that were present when a patient was admitted into the hospital.

Some examples of assistive charting include:

Stage III, IV pressure ulcers

Note any minor conditions that are present on admission as they may inherently worsen during a patients' stay at the hospital. The nurse's notes help ensure a hospital will not get stuck with the bill if something that was present on admission turns into a pressure ulcer. Therefore, thoroughly assess and document any skin conditions and/or current wounds immediately upon admission. Remember to clearly document any redness or possible underlying tissue damage in your patient's chart.

Fall or Trauma related to injury

For example, a patient is admitted with a CVA. CMS will fully reimburse the hospital the estimated costs for the treatment of that condition. Should it be revealed that the patient has a hip fracture after being admitted to the hospital, the Medicare payment would not reflect treatment of that condition. However, if the patient complained of hip pain on admission and the patient stated they fell on that affected side prior to admission and the nurse documents both, it may be considered proof that the condition existed prior to admission. Most likely payment for both diagnoses would be made.

Catheter associated Urinary Tract Infections

For example, if a patient is admitted and a foley catheter is placed, any subsequent urinary tract infection would not be reimbursed by CMS. However, if a patient is admitted with an existing foley catheter and it is documented as such, payment may be reimbursed at the optimal level. It is important for the nurse to document if a patient already has foley catheter upon admission. The characteristics of the urine must be documented. Always consult a physician if you suspect the patient already has a UTI on admission

Vascular catheter associated infections

Similar to the above catheter associated UTI's, any infection from a vascular catheter inserted after admission would result in reduction of payment. Remember to document if a patient has a vascular device on admission. Be sure to chart the assessment of that device, its dressing and condition of surrounding tissue on admission.

It is well known that, documentation provides a legal health record for the patient. This record provides the evidence of the care the patient received, a timeline of the patient's treatment and the subsequent response to that treatment. Nursing documentation is the mechanism to accurately reflect the work done by nurses. The work nurses do for their patients is important. Charting is the vehicle for nurses to be recognized for what they do. Without accurate documentation, however, credit for the nursing care received and appropriate charging cannot occur. Terri Williams, RN, E&M Level Nurse Specialist at St. John's Hospital in Springfield sums it up best by saying, "Never has nursing documentation been as important as it is right now."

How to Earn Continuing Education Credit

This course is 1.5 Contact Hours

1. Read the Continuing Education Article
2. Take the test below. Complete the entire form

DEADLINE

Answer forms must be postmarked by November 1, 2010

3. Mail or fax the completed answer form. Include processing fee as follows:

INA members—\$7.50
Non members—\$15.00

Check or money order payable to INA or credit card information only

MAIL: Illinois Nurses Association

Attn: Sharon Canariato
105 W. Adams, Suite 2101
Chicago, IL 60603

FAX: Credit Card Payments Only - 312-419-2920

ACHIEVEMENT

- To earn 1.5 contact hours of continuing education, you must achieve a score of 75%
- If you do not pass the test, you may take it again at no additional charge.
- Certificates indicating successful completion of this offering will be emailed to you

ACCREDITATION

Illinois Nurses Association is an approved provider of continuing nursing education by the Georgia Nurses Association, an accredited approver by the

American Nurses Credentialing Center's Commission on Accreditation.

TEST QUESTIONS:

You are a nurse working at your community hospital. Mr. Smith is a 70 year old male who presents to your facility with a diagnosis of Heart Failure and Fever. He lives at home with his wife and is a Medicare recipient. He has a history of Diabetes Mellitus, CVA, Rosacea, GERD and Urinary Retention. The physician orders Lasix 40 mg IVP.

1. What agency is involved in the rules and regulations regarding Mr. Smith's bill?
 - A. AHA
 - B. CMS
 - C. IRS
2. What consequence could a hospital face for not following the appropriate billing guidelines as it relates to documentation?
 - A. A reduction or elimination of payment for service.
 - B. An increase in the hospital's infection rate.
 - C. Closure of the gift shop.
3. After the nurse administers the Lasix, which statement includes all of the information the nurse should document?
 - A. Right Patient, Right Medication, Right Room Number
 - B. The amount of time it took the pharmacy to deliver the medication
 - C. The patient's name, the name of the medication, the route of the medication, the dose of the medication, the date and time the medication was given, and the patient's response to the administration of the medication.
4. Should Mr. Smith require an intravenous infusion during his admission, what nursing documentation would most greatly affect the reimbursement for the hospital?
 - A. Date and time the infusion was started, and the date of the tubing change
 - B. Date and time the infusion was started, and the name of the patient's roommate
 - C. Date and time the infusion was started, and stopped
5. What secondary diagnosis should be documented in the care plan to insure patient safety so that he does not sustain a hospital acquired injury that affects hospital reimbursement?
 - A. Rosacea
 - B. CVA
 - C. GERD

6. What important assessment on admission should the nurse be sure is documented to avoid the hospital incurring additional costs?
 - A. The characteristics of the urine and the foley catheter that was present when the patient was admitted.
 - B. The patient's bowel sounds
 - C. The patient's heart sounds

(Submit entire form below for contact hours)

ANSWER FORM CE #13:

The Nurses Role in Documentation and Reimbursement

Please circle the appropriate letter

1. A B C
2. A B C
3. A B C
4. A B C
5. A B C
6. A B C

(Please PRINT clearly)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email Address: _____

Evaluation—CE

Strongly Agree (5) Strongly Disagree (1)

Learner achievement of objectives:

1. List the rules/laws/agencies that regulate health care billing and the consequence for non-compliance. 5 4 3 2 1
2. Outline appropriate nursing documentation and its relationship to hospital reimbursement. 5 4 3 2 1

3. Identify those scenarios not reimbursed by CMS and how a nurse's documentation may assist. 5 4 3 2 1

How many minutes did it take you to read and complete this program? _____

Suggestions for improvement? Future topics? _____

METHOD OF PAYMENT

- INA Member (\$7.50) INA ID# _____
 Non Member (\$15.00)

- Money Order Check VISA
 Master Card American Express

Card account number: _____

Credit card expiration date: _____ / _____

Signature _____

Date _____

Mail all tests to: INA, Attn: Sharon Canariato, 105 W. Adams, Suite 2101, Chicago, IL 60603

References

- Centers for Medicare & Medicaid Services. (n.d.). *Hospital acquired conditions*. Retrieved September 18, 2008, from <http://www.cms.hhs.gov/apps/media/press/factsheet.asp>
 Centers for Medicare & Medicaid Services. (n.d.). *History*. Retrieved September 20, 2008, from <http://www.cms.hhs.gov/History>
 Centers for Medicare & Medicaid Services. (n.d.). *RAC permanent program*. Retrieved October 20, 2008, from <http://www.cms.hhs.gov/RAC>
 Contino, D. S. (2000). The ABCs of APCs. *Nursing Management*, 31(10), 12-16.
 Kaiser Family Foundation. (n.d.). *Illinois at a glance*. Retrieved September 25, 2008, from <http://www.statehealthfacts.org/comparemaptable>
 U.S. Census Bureau. (n.d.). *CPS health insurance definitions*. Retrieved September 20, 2008, from <http://www.census.gov/hhes>

 Practice Corner

Update on APRN Controlled Substance Authority

**Authored by Debra Funk, RN
Practice Administrator**

On March 10, 2009, the Board of Nursing staff, the Board of Healing Arts staff and the Collaborative Practice Task Force chairperson from Healing Arts' Board met to go over the draft language that we have been working on. There was a very good exchange of ideas and discussion that took place. There have been a few more changes suggested that are being investigated. I would like to thank all the APRNs across the state that have reviewed materials and provided the Board with feedback. It is important that the rules reflect current practice but at the same time the rules must also be enforceable.



Funk

We have had the opportunity to look very closely at the language contained in our current rules and in some cases have seen them from a totally different perspective. I have had several inquiries via email about the progress or lack thereof on the rules by the Board. I have tried to explain the complexity of this process and many of you have acknowledged the fact that you had no idea. We are making headway!

Documentation and Reimbursement

Typically, as nurses who are involved in the day to day care of patients, we don't really think about our documentation being used for anything other than communication between caregivers and proof of the care being provided to the patient and the patient's response to the care for legal purposes. However, this documentation is the key to how the facility may be reimbursed for the services rendered. Just because a charge is put into the computer system doesn't mean that the facility will receive reimbursement for it. There are many contracts with insurance carriers and quality criteria that must be met in order to qualify for reimbursement for many of the charges placed. Often times the most insignificant sounding piece of information can make the difference in whether the facility will qualify for payment or not.

The State of Illinois Nurse's Association recently published an article in their newsletter that described the importance of documentation to reimbursement and the role of the nurse. They have been so kind as to allow us to reprint this article for you.



Disciplinary Actions**

Pursuant to Section 335.066.2 RSMo, the Board "may cause a complaint to be filed with the Administrative Hearing Commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit, or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his certificate of registration or authority, permit or license" for violation of Chapter 335, the Nursing Practice Act.

**Please be advised that more than one licensee may have the same name. Therefore, in order to verify a licensee's identity, please check the license number.

PROBATIONARY LICENSE

Listed below are individuals who were issued an initial probationary license or had their expired or inactive licenses renewed on a probationary status by the Board during the previous quarter with a brief description of their conduct.

Name	License Number	Violation	Effective Dates of Restricted License
Aaron R. Cundall Collinsville, IL	RN153286	On May 26, 2005, Licensee pled guilty to the Class 2 Felony of Robbery. Licensee's sentence specifically provided for Licensee to receive drug treatment and counseling while incarcerated.	Probation 1/26/2009 to 1/26/2012
Amy Michelle Johnson Lake Saint Louis, MO	PN2009003283	On May 14, 2007, Licensee pled guilty to the Class C Felony of Possession of a Controlled Substance (Heroin) in the Circuit Court. The Court suspended imposition of sentence and placed Licensee on five (5) years of supervised probation.	Probation 2/5/2009 to 2/5/2014
Sarah Elizabeth Purkett Farmington, MO	RN2009004914	On August 19, 2004, Licensee entered guilty pleas to the misdemeanor charges of Supplying Liquor to a Minor and Endangering the Welfare of a Child. The Court suspended imposition of sentence and placed Licensee on two years of probation. On November 18, 2004, the Court revoked Licensee's probation for failing to complete the community service and imposed sentence for both charges.	Probation 2/25/2009 to 2/25/2010
Traci Nicole Smith Ozark, MO	PN2009000456	On October 20, 2004, Licensee pled guilty to Driving While Intoxicated. On January 13, 2005, Licensee pled guilty to Driving With an Excessive Blood Alcohol Content. On August 15, 2005, Licensee pled guilty to Driving While Intoxicated.	Probation 1/8/2009 to 1/8/2010

CENSURE

Name	License Number	Violation	Effective Dates of Restricted License
Amy Louise Caraway Maitland, FL	RN2008032899	Licensee practiced nursing in Missouri without a license from June 2007 through September 15, 2008. The Board granted Licensee a license effective October 27, 2008.	Censure 1/15/2009 to 1/16/2009
Gertrude E. Dean Richards, MO	RN077535	Licensee was employed by a hospital. During the annual State of Missouri survey for licensing of the Hospice Department, the nurse surveyor identified several signatures of the Hospice Chaplain that did not appear to be authentic. Licensee, the Hospice Director, signed the Chaplain's name to meeting minutes in a way that made it appear that the Chaplain was present at meetings, when, in fact, he was not. Licensee also signed the Chaplain's name to medical records in a way that made it appear that the Chaplain was present at meetings when individual patients and treatment plans were discussed, when, in fact, he was not. Licensee admitted to the nurse surveyor that she had signed the Chaplain's name on various records.	Censure 1/29/2009 to 1/30/2009
Wendy Dawn Henry Lilbourn, MO	PN2005025698	On August 28, 2007, licensee pled guilty to the charge of Stealing Under \$500.00 in the Municipal Court of the City of Cape Girardeau.	Censure 1/14/2009 to 1/15/2009
Angela L. Thomas Saint Louis, MO	PN058144	Licensee was to obtain fifteen (15) continuing education hours each year of probation in Nursing Law and Ethics. The hours for the first year of probation were due on June 23, 2008. At the probation violation hearing, Licensee produced proof of completion of sixteen (16) hours of continuing education. Licensee was required to submit employer evaluations from each and every employer. If Licensee was unemployed, a notarized statement indicating the dates of unemployment was to be submitted. The Board did not receive an employer evaluation or statement of unemployment by the August 4, 2008 documentation due date.	Censure 12/15/2008 to 12/16/2008
Frederika Villhard Webster Groves, MO	RN132519	Licensee was to contract with NCPS, Inc. to schedule random drug and alcohol screenings. Pursuant to the contract with NCPS, Licensee is required to call a toll free number every day to determine if she is required to submit a sample for testing that day. Licensee failed to call NCPS on twenty (20) days. Further, on May 16, 2008 and June 6, 2008, Licensee called NCPS, Inc. and was advised that she had been selected to provide a urine sample for screening. Licensee failed to report to a laboratory to provide the requested samples. Licensee was required to obtain at least fifteen continuing education hours in "Law and Ethics". The Board did not receive proof of the completed hours by the August 29, 2008, due date. The Board did receive proof of the completed hours after the due date.	Censure 12/10/2008 to 12/11/2008

The Board of Nursing is Requesting Contact from the Following Individuals:

Clifford Cecil – RN087397
 Charlene Franken – RN2000163726
 Diana McFatrich – RN145424
 Elizabeth Mott – RN148141
 Cindy A Randle – LPN050149
 Kathy Skeels-Stewart – RN144477
 Michele Smith - 2006010122
 Thomas Tucker – RN098389
 Gladys Warrior – PN 055206

If anyone has knowledge of their whereabouts, please contact Beth at 573-751-0082 or send an email to nursing@pr.mo.gov

PROBATION

Name	License Number	Violation	Effective Dates of Restricted License
Kenneth G. Barber Farmington, MO	RN107185	Licensee failed to complete admission paperwork, computer entry and to follow physician's orders. In the Pyxis reports there were numerous medication withdrawals which were not documented as being administered. Licensee appeared to be removing two doses of medication from the Pyxis. A patient was discharged and Licensee removed medication for the patient. Licensee admitted to diverting medication.	Probation 1/14/2009 to 1/14/2013
Holly Elizabeth Brown Kimberling City, MO	RN2002028261	Licensee stole 29 vials of a controlled substance from her employer for her personal use and pled guilty to felony stealing.	Probation 12/9/2008 to 12/9/2011
Cortney Jeanne Collins Joplin, MO	PN2006022599	On March 3, 2008, a discrepancy in the Accudose machine was discovered. Two (2) 20 mg. tablets of Oxycontin tablets were unaccounted for. Licensee was contacted on March 4, 2008 by her employer and requested to report to the facility to submit to a drug test. Licensee was unable to provide an adequate urine sample for the drug test. Upon being given the opportunity to provide a second sample, Licensee decided against taking the drug test and resigned immediately.	Probation 1/21/2009 to 1/21/2010
Robin R. Conant Trimble, MO	RN102598	On January 3, 2008, Licensee presented an electronically generated prescription for Darvocet N 100. On the prescription was a hand-written message, Refill 6. Upon verifying the prescription the pharmacy was advised that the prescription was written as having no refills. Licensee admitted to modifying the prescription.	Probation 12/24/2008 to 12/24/2011
Jeannette M. Daniel Tipton, MO	PN036378	Licensee asked a resident for a loan. Licensee received two checks from resident one for \$600.00 and another for \$400.00 both checks were dated November 29, 2007. Licensee was terminated and was permanently put on the Missouri Health and Senior Services Employee Disqualification list on March 12, 2008.	Probation 1/14/2009 to 1/14/2011
Craig J. Deder Saint Louis, MO	RN141923	On May 28, 2006, Police conducted a consent search and discovered that licensee was actively growing marijuana in the home. They discovered nineteen (19) plants of various sizes and an amount of cultivated marijuana. The gross weight of the marijuana was thirty-one pounds.	Probation 2/6/2009 to 2/6/2011
Diane K. Ethier Festus, MO	RN132361	On January 21, 2007, Licensee was responsible for changing a dressing. Licensee did not return calls or pages. Patient required transportation to the hospital for treatment for his wounds. Licensee was questioned about the incident, she admitted that she "forgot." On March 28, 2007, Licensee was on duty. Licensee failed to call her patients and inform them that she would be late, or call her co-workers so they could re-assign her caseload. On April 13, 2007, Licensee failed to make a scheduled home visit to care for a patient. It was discovered that Licensee had not provided wound care to Patient for six days. Per physician order, on April 14, 2007 an extra visit was scheduled to de-clot patient's bloodline. Licensee was on call on this weekend and failed to de-clot the patient's line as directed by the physician. Licensee was terminated on or about April 16, 2007.	Probation 12/24/2008 to 12/24/2010
Julie Katrin Faulkner Bismarck, MO	PN2001030501	On or about January 25, 2005, while at work, Licensee was asked to submit to a random drug screen. The urine sample tested positive for amphetamines. Licensee did not have, and has never had, a valid prescription for amphetamine.	Probation 2/20/2009 to 2/20/2011
Shawn Renee Griggs Pittsburg, KS	RN2007004352	Licensee misappropriated Hydrocodone tablets for personal consumption and replaced the Hydrocodone tablets with Naproxen. Licensee misappropriated syringes of Morphine and replaced the Morphine with Saline. Licensee glued the seal of the syringe back on to appear as though it had not been tampered with.	Probation 12/2/2008 to 12/2/2012
Cynthia L. Higgins Jefferson City, MO	PN046551	Licensee was required to undergo a thorough chemical dependency evaluation. The Board did not receive a thorough chemical dependency evaluation. Licensee was required to contract with NCPS, Inc. to schedule random drug and alcohol screenings. Licensee failed to call into NCPS, Inc. on seven (7) days.	Probation 12/15/2008 to 12/15/2010
Mary Jo Spradling-Hodges Springfield, MO	RN124970	On September 10, 2007, Licensee entered a plea of guilty to a misdemeanor charge of 3rd Degree Assault.	Probation 1/21/2009 to 1/21/2011
Lindsay Michelle Hunter Jameson, MO	PN2004025140	On or about April 17, 2005, Licensee charted she had seen and assessed inmates in administrative segregation, when in fact she had not.	Probation 2/6/2009 to 2/6/2010
Claudia D. Kramer Clever, MO	RN118429	In April 2008, the hospital's pharmacy discovered discrepancies with regard to Licensee's administration of narcotics. When confronted with the discrepancies, Licensee admitted that she had been diverting narcotics for her personal use.	Probation 12/9/2008 to 12/9/2011
Terry M. Kronshagen Pacific, MO	PN055809	On or about February 2, 2005, Licensee took duragesic patches and other medications. On or about March 24, 2006, Licensee pled guilty to Possession of a Controlled Substance, a Class C Felony.	Probation 1/22/2009 to 1/22/2013

Probation continued from page 14

Name	License Number	Violation	Effective Dates of Restricted License
Betty Ann Kruse Sedalia, MO	PN2006008613	Licensee was required to contract to schedule random drug and alcohol screenings. Licensee has failed to call in on thirty-five (35) days, including fifteen (15) consecutive days from October 16, 2008 to October 30, 2008. On the following dates: August 5, 2008, July 30, 2008, May 22, 2008 and October 5, 2007 Licensee failed to report to a laboratory to provide the requested samples.	Probation 12/15/2008 to 12/15/2011
Jonathan V. Lindley Shawnee, KS	RN140393	On or about May 13, 14 and 15, 2005, Licensee did not check for breath sounds or bowel sounds properly with the use of a stethoscope, nor did he properly check for pedal pulses by using either his fingers or a Doppler. A progress note completed by Licensee on or about May 14, 2005, indicates that the patient seems to be resting comfortably after "prn" Darvocet was administered. On or about May 14, 2005, the patient had an increase in blood pressure to 171/94 from 133/71. The Patient reported not feeling well with a lot of back pain, and complained of this to Licensee, as well as a concern that she was not getting enough fluid off. No reassessment parameters on the 72 hour assessment flow sheet indicated a recheck in the blood pressure or documentation of complaints of fluid overload. On or about May 15, 2005, Licensee charted a nursing assessment was completed for the patient. Licensee charted that every thing was within the normal limits. On or about May 17, 2006, Licensee admitted that he had charted assessments he had not done and felt that he did a visual assessment, which was sufficient. Licensee admitted that patient did not receive the care she should have.	Probation 2/14/2009 to 2/15/2009
Stephanie Dawn Medley Nixa, MO	RN137381	Licensee admitted to forging multiple prescriptions to obtain Hydrocodone.	Probation 12/24/2008 to 12/24/2012
Kimberly A. Peterson Dixon, MO	PN048837	Licensee was arrested on December 17, 2004 for dropping a bag of marijuana in the parking lot at a Correctional Facility. On April 15, 2005 Licensee pled guilty to Delivery and Possession of a Controlled Substance to a Correctional Facility/County Jail.	Probation 2/25/2009 to 2/25/2011
Shannon Jon Pfautsch Hermann, MO	PN2005033230	On September 24, 2006, Licensee tested positive for alcohol.	Probation 12/30/2008 to 12/30/2011
Shelley Ann Renkemeyer Jefferson City, MO	RN2003018687	On March 4, 2004, Licensee was asked to take a drug test which tested positive for cocaine. On April 6, 2004, Licensee called in sick from work, but was asked by her employer to report to a lab and submit to a random drug test. Licensee did so and tested positive for methamphetamine and amphetamine.	Probation 12/2/2008 to 12/2/2013
Brittany Kay Rose Festus, MO	RN2004019074	Licensee violated the terms of the Agreement by submitting a urine sample on June 9, 2008 which tested positive for ethyl glucuronide (EtG), a metabolite of alcohol.	Probation 12/15/2008 to 9/7/2011
Jay M. Rosenberg Saint Louis, MO	RN105344	Licensee violated the terms of the Agreement by failing to call in to NCPS, Inc. on eighteen (18) days and by failing to report to a collection site to provide a sample on four (4) dates that he had been selected to submit to a random drug screening.	Probation 12/15/2008 to 10/31/2009
Nicole Rene Scott Saint Louis, MO	PN2005013246	On December 14, 2007, Licensee pled guilty to the Class C Felony of Stealing Over Five-Hundred Dollars. The Court suspended imposition of sentence and placed Licensee on five (5) years of supervised probation.	Probation 1/21/2009 to 12/14/2012
Nancy B. Shoemaker Malden, MO	RN083725	In November 2007 there were thirteen (13) Hydrocodone 7.5 APAP 500 mg and eighteen (18) Hydrocodone 10 APAP 650 mg missing. A camera was installed, the tape showed Licensee opening the narcotic cabinet, removing and opening a bottle, taking pills out and putting them into another bottle. Licensee then returned the original bottle and left with the misappropriated pills.	Probation 1/20/2009 to 1/20/2014
Terry Lynn Sills Baxter Springs, KS	PN2008037093	On August 11, 1998, Licensee voluntarily surrendered her Missouri licensed practical nursing license. Licensee was being investigated by the Board for ordering prescriptions for herself and her co-workers using the name and DEA number of a physician she worked for. Licensee acknowledges that, due to personal issues and taking excessive amounts of Xanax, she made some extremely poor decisions.	Probation 12/18/2008 to 12/18/2010
Alisha Tai Smith Columbia, MO	PN1999136957	While employed at Correction Medical Services, Licensee engaged in an intimate relationship with an inmate. Inmate had sexual relations with Licensee, while Licensee was on duty.	Probation 1/15/2009 to 1/15/2010
Karen S. Weflen Saint Louis, MO	RN075546	On or about December 10, 2004, Licensee was reported to have slurred speech and an unsteady gait while on duty, a drug screen tested positive for opiates. On or about January 6, 2005, Licensee signed a "Return to Work Agreement". On or about August 22, 2005, Licensee was terminated for failing to comply with her "Return to Work Agreement" when Licensee admitted she had relapsed in July 2005 and was voluntarily seeking treatment.	Probation 2/12/2009 to 2/12/2012
Lizzie R. Williams Venice, IL	PN035487	Licensee consumed alcoholic beverages impairing her ability to perform her work as a practical nurse, engaged in misconduct in the performance of her professional functions and duties, and violated the professional trust and confidence of her patients, co-workers and employer.	Probation 12/9/2008 to 12/9/2010

REVOKE

Name	License Number	Violation	Effective Dates of Restricted License
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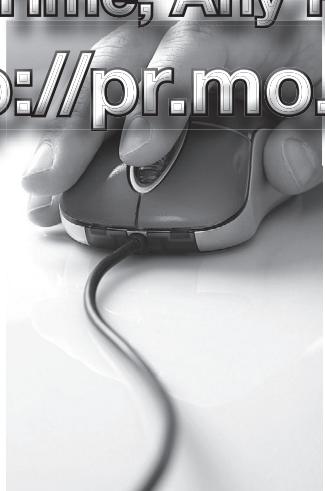
Donna Nellene Brown Alton, MO	PN2004003376	Licensee was required to submit an evaluation form from each and every employer. If Licensee was not employed at any time during the period of discipline, she was to submit an affidavit signed before a notary public stating the period(s) of unemployment. The Board did not receive an employer evaluation or statement of unemployment on behalf of Licensee by the September 16, 2008 documentation due date. Licensee was required to renew her nursing license immediately. On May 31, 2008, Licensee's license expired and remains lapsed at this time.	Revoked 12/10/2008
Daren K. Cartwright Peculiar, MO	PN058009	Licensee was required to abstain from the use or consumption of alcohol. On April 24, 2008 and August 13, 2008, Licensee submitted urine samples for random drug and alcohol screening. The samples tested positive for the presence of ethyl glucuronide, a metabolite of alcohol. Licensee was required to keep his nursing license current. On May 31, 2008, Licensee's license expired. Licensee renewed his license on November 7, 2008.	Revoked 12/10/2008
Joseph T. Kurre Collinsville, IL	RN124704	Licensee, through a professional recruiting company, expressed an interest in relocating to Hartsville, South Carolina to practice pediatrics. The Hospital received a curriculum vitae from Licensee representing that Licensee was licensed by the Missouri Board of Registration for the Healing Arts as a physician. The Hospital purchased airline tickets for Licensee and his wife in the amount of \$1,042.60 and also agreed to pay Licensee's other travel expenses for his visit to Hartsville, South Carolina. The Hospital incurred a total of \$3,041.02 in expenses associated with Licensee's visit to Hartsville, South Carolina. During the time period which Licensee was posing as a physician and applying for pediatric physician positions at the Hospital, he was employed as a registered professional nurse. Licensee has never been licensed by the state of Missouri as a physician nor does Licensee possess the requisite education, skills or training to hold himself out as a physician.	Revoked 12/10/2008
A.J. McCain, Jr. Rogers, AR	PN030647	On February 5, 1993, Licensee's name was placed on the Department of Health and Senior Services Employee Disqualification List permanently.	Revoked 12/10/2008
Barbra D. McCarty Wahiawa, HI	PN057678	Licensee was required to meet with the Board or its professional staff at such times and places as required by the Board. Licensee was advised, by certified mail, to attend a meeting with the Board's representative. As Licensee lived out of state, the letter advised Licensee that the meeting would be held via teleconference. The letter requested Licensee to provide the Board with a telephone number where she could be reached for the meeting and for an e-mail address in order to send the meeting affidavit. Licensee failed to provide the requested information and did not call or attend the meeting. Licensee was required to contract with NCPS, Inc. and participate in random drug and alcohol screenings. Licensee never completed the contract process with NCPS, Inc. Licensee was required to undergo a thorough evaluation for chemical dependency performed by a licensed chemical dependency professional. The Board never received a thorough chemical dependency evaluation submitted on behalf of Licensee.	Revoked 12/10/2008

Revoked continued on page 17

Revoked continued from page 16

Name	License Number	Violation	Effective Dates of Restricted License
Christina A. Oster Saint Mary, MO	PN058256	Pursuant to the decision of the Administrative Hearing Commission, the Board has jurisdiction to discipline Licensee's license pursuant to the provisions of §335.066.2 (1), (2), (5), (12) and (14) RSMo.	Revoked 12/10/2008
Jerry D. Perry Columbia, MO	PN015842	Licensee was to complete the NCPS urine drug screen packet and submit the completed contract to NCPS. Licensee failed to complete the contract process with NCPS. Licensee was to undergo a thorough chemical dependency evaluation and have the result sent to the Board within ten working days after its completion. The Board never received a thorough chemical dependency evaluation submitted on Licensee's behalf. Licensee was required to renew his license immediately. Licensee's license remains lapsed.	Revoked 1/26/2009
Adrienne Francine Piatt Salem, MO	PN2008022854	Licensee was required to abstain completely from the use or possession of any controlled substance or other drug for which a prescription is required unless use of the drug has been prescribed by a person licensed to prescribe such drug and with whom Licensee has a bona fide relationship as a patient. On August 29, 2008, Licensee submitted a urine sample for a pre-employment drug screening. That sample tested positive for the presence of marijuana.	Revoked 12/10/2008
Christina L. Robertson Fisk, MO	PN055483	On or about September 22, 2004, Licensee falsified a service delivery document titled "Provider Nurse Evaluation" for an in-home services recipient. Licensee falsified the patient's service delivery document on or about September 22, 2004 by: 1) indicating on the document that an aide had provided in-home services to the patient on or about September 22, 2004 when no services had been provided and when the aide had never even met the patient; and 2) forging the aide's signature on the document. On September 6, 2005, Licensee was placed on the Missouri Department of Health and Senior Services Employee Disqualification List ("Missouri EDL") because she falsified the patient's Home Care service delivery document on or about September 22, 2004. Because Licensee falsified the service delivery document, on July 24, 2007, in the Circuit Court of Butler County, MO, case no. 36R010500678, Licensee also pled guilty to a class A misdemeanor pursuant to RSMo §660.305.3.	Revoked 12/10/2008
Harold Curtis Smith	RN2006012513	Licensee was required to contract with NCPS, Inc. and participate in random drug and alcohol screenings. Pursuant to the contract, Licensee was required to call a toll free number every day to determine if he is required to submit to a test that day. Respondent failed to call into FirstLab or NCPS, Inc. on forty-three (43) days.	Revoked 12/10/2008
Julie L. Taylor Poplar Bluff, MO	RN132758	Pursuant to a decision of the Administrative Hearing Commission, the Board has jurisdiction to discipline Respondent's license pursuant to the provisions of § 335.066.2 (1), (5), (12) and (14) RSMo.	Revoked 12/15/2008
Theresa K. Thoman Kansas City, KS	PN049395	Licensee was required to meet with representatives of the Board at such times and places as required by the Board. Licensee was advised, by certified mail, to attend a meeting with the Board's representative. Licensee failed to attend the meeting or call to reschedule. Licensee was required to contract with NCPS, Inc. and participate in random drug and alcohol screenings. Licensee has failed to comply with the contractual requirements of NCPS. Licensee was required undergo a thorough chemical dependency evaluation have the results sent to the Board. The Board has never received a thorough chemical dependency evaluation submitted on Licensee's behalf.	Revoked 12/10/2008
Scott Lane Vantine Kansas City, MO	RN2003016039	Licensee was required to cause the Kansas Nurse Assistance Program (KNAP) to submit a letter to the Board outlining Licensee's progress with KNAP. The Board did not receive a status report from KNAP by the September 25, 2008 due date.	Revoked 12/10/2008

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SUSPENSION

Name	License Number	Violation	Effective Dates of Restricted License
Belinda C. Karney Columbia, MO	RN084757	Licensee was required to undergo a thorough chemical dependency evaluation from a chemical dependency professional and have the results sent to the Board. Licensee met with a therapist for the evaluation. However, the therapist noted that, Client reported to the writer at the beginning of the assessment that she understands the assessment process and would not disclose any information regarding her drug use or need for therapy. By failing to provide complete and accurate information to the therapist, Licensee has violated the terms of her probation which required her to undergo a thorough evaluation. Licensee was required to submit employer evaluations from each and every employer. If Licensee was unemployed, a statement indicating the dates of unemployment was to be submitted in lieu of the employer evaluation. The Board did not receive an employer evaluation or statement of unemployment by the first documentation due date of October 8, 2008.	Suspension 12/10/2008 to 6/10/2009 Probation 6/11/2009 to 6/11/2014
Margaret Helen Mears Kansas City, MO	PN2000170578	Licensee violated the terms of the Agreement by failing to call in to NCPS, Inc. on forty-three (43) days and by failing to report to a collection site to provide a sample on one (1) date that she had been selected to provide a sample.	Suspension 12/15/2008 to 1/14/2009 Probation 1/15/2009 to 5/11/2010
Wilma J. Sadler Sikeston, MO	RN113882	Licensee documented the administration of several bolus doses of Morphine although there was no physician's order for the bolus doses. Licensee diverted Morphine from the patient for her personal use and she also diverted Morphine and Fentanyl on other occasions. Licensee diverted at least 25 micrograms of Fentanyl near the end of September 2007 and she consumed a bolus dose of Morphine from a PCA pump on October 16 and October 17, 2007 while on duty. On October 17, 2007, Licensee injected 2 milligrams of Morphine while on duty.	Suspension 1/15/2009 to 1/15/2010 Probation 1/16/2010 to 1/16/2015

VOLUNTARY SURRENDER

Name	License Number	Violation	Effective Dates of Restricted License
Sharon K. Dulin Brookline, MO	PN036796	Licensee submitted to a urine drug screen. This drug screen tested positive for marijuana.	Voluntary Surrender 2/13/2009
D. Adam Snell Alton, IL	RN145764	On October 14, 2008, the Missouri Administrative Hearing Commission issued a decision finding that the Board had grounds to discipline the nursing license of Licensee pursuant to §335.066.2(8), RSMo.	Voluntary Surrender 12/30/2008



4,000 Missouri Medical Providers Trained on Avoiding Medical Errors



Jefferson City, Mo.—Staff and board members from the Missouri Board of Nursing were among more than four thousand medical professionals statewide to receive training aimed at preventing errors at hospitals, clinics, nursing homes and other settings. The year-long training program called the Just Culture Collaborative was funded by a \$254,240 grant from the National Council of State Boards of Nursing, and administered by the Missouri Center for Patient Safety.

Seminar attendees included doctors, nurses and administrators from hospitals, doctors' offices, nursing homes, mental health facilities and others. The grant money was requested after a 2004 report on medical errors in Missouri that pointed to a culture of blame, rather than a system that allowed health care providers to learn from mistakes and prevent them in the future.

"Missouri must have a system for making corrections after mistakes are made," said Lori Scheidt, Executive Director of the Board of Nursing. "Punishing those responsible is not always the answer, and without corrections to systems, these same serious medical errors will occur."

Attendees were trained on the use of human factors engineering concepts, identification of at-risk behavior and reckless behaviors and the use of disciplinary and regulatory processes to address medical errors. The Board of Nursing is one of 67 groups that took part in the training program, which was an unusual collaboration between state regulators and the licensed industries they oversee. Conclusion of the year-long training effort was celebrated at the Center for Patient Safety's third annual conference on April 7 in Columbia.

NCSBN Implements Epush Technology

Chicago—The National Council of State Boards of Nursing (NCSBN) has implemented Epush technology to its Web site, giving <http://www.ncsbn.org/> visitors the opportunity to have NCSBN news and updates sent directly to their inbox.

Newsletters, news releases and information about numerous NCSBN products and services can now be directly sent to users via e-mail. Users can choose up to 10 categories of interest, including: *Leader to Leader*; *LINK*; *Council Connector*; news releases; information about the NCLEX-RN, NCLEX-PN, NNAAP and MACE examinations; e-learning updates; and events notification. Users customize their preferences to receive only the information that is of interest to them.

"We are very excited about this new tool," said Kathy Apple, MS, RN, CAE, chief executive officer, NCSBN. "Epush allows users to receive news about the NCLEX exams, nursing regulation and new publications instantly. This technology enables NCSBN to provide the most up-to-date information quickly and conveniently to those who have selected to receive it."

The National Council of State Boards of Nursing, Inc. (NCSBN) is a not-for-profit organization whose membership comprises the boards of nursing in the 50 states, the District of Columbia and four U.S. territories.

Mission: The National Council of State Boards of Nursing (NCSBN), composed of Member Boards, provides leadership to advance regulatory excellence for public protection.

Missouri Statute Limits Mercury in Immunizations for Pregnant Women and Children Under 3

A message from the Director of the Missouri Department of Health and Senior Services, Margaret T. Donnelly

January 2009 - In an effort to raise awareness of Section 191.235, RSMo, a statute affecting the administration of certain immunizations in Missouri, we ask you to review the information and ensure your practice and/or areas of professional responsibility reflect the requirements of the statute.

On April 1, 2007, Section 191.235, RSMo, was enacted in Missouri. This state statute prohibits the administration of an immunization with more than one microgram of mercury per five-tenths-milliliter dose to knowingly pregnant women or to children less than three years of age. Mercury is a component of thimerosal found in few vaccines. Many influenza vaccines do contain this preservative and should not be administered to pregnant women and children less than three years of age. Preservative-free influenza vaccines are available and should be ordered, according to this statute.

If you need additional information, please contact the Bureau of Immunization Assessment and Assurance at (573) 751-6124. Our public health system relies on dedicated health professionals to ensure the health of Missourians. To review the statute, go to <http://www.moga.mo.gov/statutes/>

MSBN Turns 100! Let's Celebrate!

This year the Missouri State Board of Nursing is 100 years old. In our November 2009 issue we would like to include an article celebrating 100 years of nursing in Missouri.

Your Input is Requested

Send us your nursing stories, photos, or your thoughts about changes in nursing over the last 100 years for possible inclusion in our November edition.

Looking for Former Board Members

Over the years over 140 individuals have been appointed as members of the Board. If you are a past Board member we would like to hear from you! Send us a note about your experience on the Board. Below is the list of individuals appointed to the Board from 1909 to present.

Elizabeth Tooker, RN*
Ida Gerding, RN*
Maude Landis, RN*
Charlotte Forrester, RN*
Fanny E. S. Smith, RN*
 Mabel L. Freytag, RN
 Mrs. Mary Morrow, RN
 Sallie J. Bryant, RN
 Mrs. Mary Nelson, RN
 Anna Gillis, RN
 Helen Bridge, RN
 Annie Whitaker, RN
 Delphine Weeks, RN
 Helen Wood, RN
 Mary G. Burman, RN
 Mrs. Louise K. Ament, RN, MD
 Helen Farnsworth, RN
 Helen Wood, RN
 Delia O'Neil, RN
 Rose Hales, RN
 Dr. Edward Saunders
 Sina Cochran (Vaughn), RN
 Dr. Louis J. Wolfert
 Mathilda Papenhausen, RN
 L. Eleanor Keely, RN
 Ruth Story, RN
 Sister Mary Giles Phillips, RN
 Mrs. Bonnie Meyers, RN
 Dr. Charles Hyndman
 Mabel Kehoe, RN
 Sister M. Geraldine Kulleck, RN
 Clara Louise Hilligass, RN
 Lela Rahe Smith, RN

Dr. Max Starkloff
 Della Jarboe Ream, RN
 Luna Thomas, RN
 Corinne Hamilton, RN
 William C. Weinsberg, MD
 Grace Frauens, RN
 Ophelia Mae Perkins, RN
 Elizabeth McIntosh, RN
 Paul Murphy, MD
 Nelle Morgan, RN
 Lucy Hoblitzelle, RN
 Alma Van Matre, LPN
 Loucretta Watson, LPN
 Sr. Mary Fabian Hutt, RN
 Gladys Combs, RN
 Alice Henderson, RN
 Ruby Hart, RN
 Edna E. Peterson, RN
 Margaret Riley, LPN
 Emilia Jones, RN
 Sr. M. Helen Doerr, RN
 Mary Ellen Warstler, RN
 Jo Ann Jackson Todd, RN
 Mildred Owens Campbell Snell, LPN
 Mary Ruth Cuddy, RN
 Lucille Ferry, RN
 Frances Beck Kelly, RN
 Margie McDole, RN
 Minnie Edythe Gore, RN
 Sr. Mary Isadore Lennon, RN
 Myla Hutchens, RN
 Anna V. Sneathen, LPN
 Uva M. Busby, LPN
 Clare Eisenbach, RN
 Una Thomas, RN
 Florence Harris, LPN
 Florena Carlstrom, LPN
 Norma Wilson, LPN
 Sr. Mary Jeremy Buckman, RSM, RN
 Janet Port, RN
 Zella Harrington, RN
 Edna Barbee, LPN
 Audrey Roberts Jenkins, RN
 Virginia Gayle Collins, LPN
 Rose Marie Hilker, RN
 Mary Lou George, RN
 Jo Nell Musgrave, LPN
 Sharon L. Summers, RN
 Marlene J Grissum, RN
 Norma Wolfe, LPN
 Gueniver B. Gevecker, RN
 Mary Catherine (Kate) DeClue Schejbal, RN
 N. Virginia Cook, LPN
 Marilyn Meinert, RN
 Peggy Lee Prim, RN
 Mattye Wright Jones, LPN
 Carolyn Elizabeth Edison, RN
 Elora (Sissy) Borgmeyer, Public Member
 Brenda G. Ernest, RN

Mary Mitchell, RN
 Jacqueline Hartz, RN
 Joyce Neaves, RN
 Shael Lawson, LPN
 Peggy Ellis, RN
 Walter Rerrick, Public Member
 Barbara Keay, LPN
 Patricia Alft, RN
 Marilyn Jacobs, RN
 Carol Jaco, RN
 Barbara Schaffitzel, RN
 Cheryl Primm, RN
 Evelyn Talton, LPN
 Susan Morgan, RN
 Patricia Dixon, RN
 Karen Hendrickson, RN
 Betty Butler, LPN
 Richard English, Public Member
 Joyce Haynie, LPN
 Delores Ware, RN
 Toni Sullivan, RN
 Sr. Jeanne Meurer, RN
 Katherine J Smolik, RN
 Ian M. Davis, LPN
 Laura Murphy-Dellos, RN, MSN, CNM
 Patricia Porterfield, RN
 Patricia Versluis, RN
 Paul Lineberry, PhD, Public Member

Charlotte York, LPN**
 Cordelia M. Esry, PhD, RN
 Robin S. Vogt, PhD, RN, FNP-C

Janet Anderson, RN
 Arthur A. Bante, RN, CRNA
 Teri A. Murray, PhD, RN
 Hillred Kay Thurston, ADN, RN
 Janet Vanderpool, MSN, RN
 Linda Conner, BSN, RN
 David W. Barrow, LPN
 Cynthia A Suter, JD
 David G. Potter, CRNA
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 Deborah J Barger, MSN, RN
 K'Alice Breinig, RN
 Clarissa McCamy, LPN
 Mark F. Miller, CRNA
Autumn Hooper, RN**

Margaret (Meg) Shea, RN, PNP-BC
 Teresa K. McElyea, LPN
 Janet Vanderpool, MSN, RN
 Kelly Scott, MSN, RN, BC, FNP
Lisa Green, PhD(c), RN**
Aubrey F. Moncrief, CRNA**
Adrienne A. Fly, JD, Public Member**
Rhonda Shimmens, RN, BSN, C**
Deborah Wagner, RN**

*Member of original State Board of Nursing Examiners

**Member of current Missouri State Board of Nursing



American Association of Colleges of Nursing

ADVANCING HIGHER EDUCATION IN NURSING

Despite Surge of Interest in Nursing Careers, New AACN Data Confirm that Too Few Nurses are Entering the Healthcare Workforce

Passing the NEED Act of 2009 Would Address Resource Concerns at Schools of Nursing and Spark Future Enrollment Growth

WASHINGTON, DC, February 26, 2009—According to new survey data released today by the American Association of Colleges of Nursing (AACN), less than half of all qualified applicants to entry-level baccalaureate nursing programs were enrolled last year despite calls to increase the number of well-educated registered nurses (RNs) in the U.S. workforce. Though interest in nursing careers is high, the latest data show that almost 50,000 qualified applications to professional nursing programs were turned away in 2008, including nearly 6,000 applicants to master's and doctoral degree programs.

"Nursing schools nationwide continue to see a strong interest in nursing careers among high school graduates and career changers looking for a dynamic, secure profession," said AACN President Fay Raines. "Tempering this good news, however, is the fact that academic administrators are facing many barriers to accepting all qualified applicants into their nursing programs, including funding cuts, limited classroom and clinical space, and a diminishing pool of faculty. All efforts to end the nursing shortage and enhance the pipeline of nursing students must focus on addressing these serious concerns."

"AACN has zeroed in on a growing national problem – a nursing shortage and a desperate lack of nursing teachers," said Senator Richard Durbin (D-IL), Majority Whip. "Every year, our colleges and universities turn away more and more aspiring healthcare professionals due to lack of faculty. Last year over 2,500 potential nursing students in my home state of Illinois were turned away. The Nurse Education, Expansion, and Development (NEED) Act that I introduced with Congresswoman Lowey will strike at the heart of the nursing shortage by giving colleges the resources they need to train more nurses."

AACN's latest data report updates the preliminary data released in December 2008 and determines enrollment trends by comparing data from the same schools reporting in both 2007 and 2008. Final survey data show that enrollments in entry-level baccalaureate programs in nursing rose by 2.2% in 2008, a slight increase above the earlier reported increase of 2.0%. Though this growth is welcome, the number of new students in baccalaureate programs falls far short of meeting projected needs. Last year, The Council on Physician and Nurse Supply, an independent group of healthcare leaders based at the University of Pennsylvania, called for 30,000 additional baccalaureate-prepared nurses to be graduated annually to meet the nation's workforce needs, an expansion of 30%. This year's 2.2% increase translates into an increase of only 3,069 entry-level students.

"Increasing enrollment in baccalaureate nursing programs is a critical first step to correcting an imbalance in the nursing student population and reversing our nation's diminishing supply of nurse educators," said AACN CEO and Executive Director Geraldine "Polly" Bednash. "In almost all jurisdictions, nursing faculty must possess a graduate degree in order to assume a full-time teaching role. Since the overwhelming majority of nurses with master's and doctoral degrees began their education in baccalaureate programs, efforts to alleviate the faculty shortage must focus on expanding enrollments in four-year nursing programs."

Other key findings from AACN's 2008 survey include the following:

- Applications & Acceptance Rate: In the 2007-2008 academic year, 190,483 completed applications were received for entry-level baccalaureate nursing programs with 122,001 meeting admission criteria and 80,616 applications accepted. These data translate into an acceptance rate of 42.3%. For a graphic showing a five-trend in applications received, see <http://www.aacn.nche.edu/Media/pdf/EnrollChanges.pdf>.
- Total Enrollment: The AACN survey found that

total enrollment in all nursing programs leading to the baccalaureate degree is 201,407, an increase from 192,698 in 2007. Within this universe, 145,845 students are enrolled in entry-level baccalaureate nursing programs. In graduate programs, 69,565 students are enrolled in master's programs, and 7,391 are enrolled in doctoral nursing programs.

- Survey Response: AACN's findings are based on responses from 663 nursing schools (87%) in the U.S. and its territories that grant baccalaureate and/or graduate degrees. AACN data reflect actual counts reported in Fall 2008 by nursing schools, not projections or estimates based on past reporting.
- Student Diversity: Graduate nursing programs realized the greatest gains in the number of students from minority backgrounds over the past year. Though representation in baccalaureate nursing programs remained high at 26%, the proportion of minority students in master's programs increased to 24% (up 1,803 students) and to 22.2% in research-focused doctoral programs (up 41 students). For 10-year data on diversity in nursing education programs, see <http://www.aacn.nche.edu/IDS/statedata.htm>.
- Men in Nursing: Though men represent only 5.8% of the U.S. nursing workforce, the percentage of men in baccalaureate and master's nursing programs are 10.4% and 8.9%, respectively. In doctoral programs, 7.1% of students in research-focused programs and 10.2% of students in practice-focused programs are men.
- Accelerated Programs: Accelerated nursing programs continue to be an important pathway into nursing for individuals with degrees in other fields who are looking to change careers. Last year, 13 new accelerated baccalaureate programs were launched, bringing the nationwide total to 218 programs. Currently, 11,018 students are enrolled in these programs, up from 9,938 in 2007, and the number of graduates has climbed to 6,870 graduates in 2008. In the 57 accelerated master's degree programs now available, 4,577 students are enrolled, and 1,177 students graduated last year. See <http://www.aacn.nche.edu/Media/FactSheets/AcceleratedProg.htm>.
- Degree Completion Programs: Given the calls for a more highly educated nursing workforce, AACN was pleased to see growth in degree completion programs for RNs looking to earn a baccalaureate or master's degree. From 2007 to 2008, enrollment in RN-to-Baccalaureate programs increased by 8.2%, which marks the sixth year of enrollment increases. Currently, 621 RN-to-Baccalaureate and 160 RN-to-Master's Degree programs are available nationwide with many programs offered completely online. See <http://www.aacn.nche.edu/Media/FactSheets/DegreeCompletionProg.htm>.
- Clinical Nurse Leader: The national movement to advance the new Clinical Nurse Leader® (CNL) role gained momentum last year with 11 new CNL programs opening, which brings the total number of programs to 81. Currently, 1,650 students are enrolled in these generalist master's programs (up 29.9%) and 467 CNLs graduated last year (up 76.2%). For details on the CNL, see <http://www.aacn.nche.edu/CNL>.
- Baccalaureate to Doctoral Programs: One innovative program that is gaining momentum and helping to bring younger faculty into nursing is the Baccalaureate to Doctoral program. AACN's latest survey shows that 72 Baccalaureate to Doctoral programs are now available, up from 63 programs in 2007, with an additional 11 programs under development. See <http://www.aacn.nche.edu/IDS/pdf/BACDOC.pdf>.
- Doctoral Nursing Programs: Though the overall number of nursing students in doctoral programs has increased by 20.9% from 2007 to 2008, enrollment growth has been limited to Doctor of Nursing Practice (DNP) programs. In research-focused doctoral programs (i.e. PhD, DNSc), enrollments

increased by only 0.1% or 3 students last year with the total student population reaching 3,976. The number of enrollees in DNP programs nearly doubled during that same timeframe with the student population growing from 1,874 to 3,415 students (82.2%). In terms of doctoral program graduates, 555 students graduated from research-focused programs in 2008, and 361 graduated from DNP programs.

Students Turned Away Reaches New High

Though interest in baccalaureate and graduate nursing programs is strong, thousands of qualified applicants are being turned away from four-year colleges and universities. In fact, AACN's survey found that 49,948 qualified applications were not accepted at schools of nursing last year due primarily to a shortage of faculty and resource constraints. Within this total, applications turned away include 41,385 from entry-level baccalaureate, 1,659 from RN-to-Baccalaureate, 5,902 from master's, and 1,002 from doctoral programs.

The top reasons reported by nursing schools for not accepting all qualified students into entry-level baccalaureate programs, include a lack of faculty (62.5%), insufficient clinical teaching sites (53.8%), limited classroom space (42.3%), insufficient preceptors (25.4%) and budget cuts (14.8%). For a graphic showing the number of qualified applicants turned away from entry-level baccalaureate nursing programs over the past seven years, see <http://www.aacn.nche.edu/Media/pdf/TurnedAway.pdf>.

Advancing Solutions to the Nursing Shortage

With the goal of expanding student capacity, schools of nursing across the country are working to find creative ways to accept more qualified students into their programs. AACN is working to facilitate these efforts by advocating for federal legislation that benefits nursing education, including the establishment of a capitation grant program through the NEED Act that was introduced today by Senator Richard Durbin (D-IL). In the 110th Congress, this legislation was championed by Reps. Nita Lowey (D-NY), Peter King (R-NY), and Lois Capps (D-CA) in the House and Senator Richard Durbin (D-IL) in the Senate.

"At a time when job loss and unemployment have affected so many sectors of our economy, it is inexcusable that funding and resource constraints at nursing schools are preventing us from filling gaps in the nursing workforce," said Congresswoman Nita Lowey (NY-18). "In 2008, baccalaureate and graduate nursing schools in New York turned away 2,134 qualified applicants, 550 more students than last year. That is why I have introduced and supported the NEED Act since 2004. This legislation will help schools of nursing accommodate and train more qualified applicants so health care providers can hire the workforce they need."

AACN commends the work of President Obama and Congress in the past few weeks to enact legislation that will support nursing students and schools across the country. The American Recovery and Reinvestment Act, the House passage of the Omnibus Appropriations Act, and the President's FY 2010 budget overview document (released today) all support solutions to address the critical shortage of nurses.

AACN will continue to focus its resources on working with policy-makers to support schools of nursing in their efforts to expand student and faculty populations. "A successful solution to the shortage of RNs and nurse faculty will require a collaborative effort on the part of the nursing profession, federal legislators, the healthcare system, and all stakeholders," said Dr. Raines. "Together, we must remove barriers to nursing careers, provide incentives for nurses to advance their education, and create practice environments that encourage professional development and foster retention."

Despite Surge of Interest continued from page 20**About the AACN Survey**

AACN's 28th Annual Survey of Institutions with Baccalaureate and Higher Degree Nursing Programs forms the basis for the nation's premier database on trends in nursing school enrollments and graduations, student and faculty demographics, and faculty and deans' salaries. Complete survey results are compiled in the report 2008-2009 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing, which may be ordered online at <http://www.aacn.nche.edu/IDS/datarep.htm>. Details about AACN's annual data reports on faculty and dean salaries will be available in late March 2009.

The American Association of Colleges of Nursing (AACN) is the national voice for university and four-year college education programs in nursing. Representing more than 640 member schools of nursing at public and private institutions nationwide, AACN's educational, research, governmental advocacy, data collection, publications, and other programs work to establish quality standards for bachelor's- and graduate-degree nursing education, assist deans and directors to implement those standards, influence the nursing profession to improve health care, and promote public support of baccalaureate and graduate nursing education, research, and practice. www.aacn.nche.edu

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Name/Address Change Form

Did you know you are required to notify the Board if you change your name or address? Missouri Code of State Regulation [(20 CSR 2200-4.020 (14)(b) (1)] says in part "If a change of name has occurred since the issuance of the current license, the licensee must notify the board of the name change in writing..... "and (2) If a change of address has occurred since the issuance of the current license, the licensee must notify the board of the address change...."

Note: change of address forms submitted to the post office will not ensure a change of address with the Board office. Please notify the board office directly of any changes.

Type or print your change information on the form below and submit to the Board Office.

Name and/or address changes require a written, signed submission.

Please complete all fields to ensure proper identification.		
<input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> NAME CHANGE <input type="checkbox"/> ADDRESS CHANGE <input type="checkbox"/> PHONE CHANGE		
Missouri Nursing License Number:		
Date of Birth:		
Social Security Number:		
OLD INFORMATION (please print):		
Name: First	Middle	Last
Address:		
City:	State:	Zip Code:
Daytime Phone Number	Alternate Phone Number	
NEW INFORMATION (please print)		
Name: First	Middle	Last
Address (if your address is a PO Box , you must also provide a street address):		
City:	State:	Zip Code:
Daytime Phone Number:	Alternate Phone Number:	
Email (optional)	Fax Number (optional)	
Signature (required)		
Date		

Please submit your change(s) by:

Fax: 573-751-6745 or 573-751-0075 or

Mail: Missouri State Board of Nursing, P O Box 656, Jefferson City MO 65102

Duplicate license instructions:

It is not mandatory that you obtain a duplicate license. You may practice nursing in Missouri as long as your Missouri nursing license is current and valid. If you wish to request a duplicate license reflecting your new name, you must return ALL current evidence of licensure and the required fee of \$15.00 for processing a duplicate license.

Return this completed form to: Missouri State Board of Nursing, P O Box 656, Jefferson City, MO 65102

Is Your License Lost or Has It Been Stolen?

If you would like to obtain a duplicate license because your license has been lost or stolen. Please contact our office and request an Affidavit for Duplicate License form or you may obtain it from the *Licensure Information & Forms* tab on our website at <http://pr.mo.gov/nursing.asp>